STATE OF MARYLAND—CERTIFICATE OF DEATH

04671

1. PLACE OF DEATH

County Balto. Registration Dist. No. 34

Village or City Upperco No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Ralph Roger Abbott

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of X

6. DATE OF BIRTH (month, day, and year) Mch 7 - 1945

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	24	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. none

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Balto Co. (State or country) Md.

FATHER

13. NAME Wm Russell Abbott

14. BIRTHPLACE (city or town) Balto. Co. (State or country) Md.

MOTHER

15. MAIDEN NAME Helen Irene Spencer

16. BIRTHPLACE (city or town) Carroll Co. (State or country) Md.

17. INFORMANT Helen Irene Abbott

(Address) Upperco, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place St. Pauls-Upperco Date May 21, 1945

19. UNDERTAKER Father Wm Russell Abbott

(Address) Upperco, Md.

20. FILED May 21, 1945 Cyril E. Frankle M.D.

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 21 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19

I last saw him alive on dead May 21, 1945; death is said to have occurred on the date stated above, at 6 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importence were as follows:

	Date of onset
Whooping Cough	

Other Contributory Causes of importance:

Name of operation Date of

Whet test confirmed diagnosis? Was there an autopsy?

23. If death was due to externel causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Data of injury , 19

Where did injury occur? (Specify city or town, county and State)

Spacify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury

Nature of injury

24. Wes disaasa or injury in any way related to occupation of deceesed?

If so, specify

(Signed) Cyril E. Frankle M. D.

(Address) Upperco, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Dr. Grott

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

64672

P

Reg. Dist. No.

1. PLACE OF DEATH:

County: Parkville

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
3031 Putty Hill Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Parkville

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3031 Putty Hill Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Antonio Agnello

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Angelina Agnello

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1st, 1885

8. AGE: Years	Months	Days	If less than one day
60	--	8	hrs. min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Shoe Repairing

11. Industry or business

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Mrs. Angelina Agnello
Address: 3031 Putty Hill Avenue

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/12/45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore

18. Funeral director: Leonard J. Ruck

Address: 5305 Harford Road

19. 5/10 45 A W Kedrick
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 5/9 1945, to 5/9 1945 and that I last saw h[illegible] alive on 5/9/45 1945

Immediate cause of death	DURATION
Coronary thrombosis	1 hr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. A. Grott, M. D. or other

Address: 8100 Harford rd Date signed: 5/9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 046738

P

(M)

VS A15 (7)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Baltimore
City or town Timonium, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Cinder Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Timonium
(If outside city or town limits, write RURAL and give nearest town)
Street No. Cinder Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Albright

3.(b) Social Security Number none

4. Sex: M.
5. Color or race: W.
6. If Single, married, widowed, or divorced: Married.

6.(b) Name of ~~husband~~ or wife: Leone Hutchins Albright
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 9 1878

8. AGE: Years 66 | Months 11 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Co., Md. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business

FATHER
12. Name: Charles Albright
13. Birthplace: Germany

MOTHER
14. Maiden name: Amelia ?
15. Birthplace: Germany

16. Informant: Mrs. Thomas Etzkorn
Address: 408 Alabama Rd., Towson 4, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29, 1945 (month) (day) (year)
Cemetery or crematory: St. John's Lutheran Cem.
Location: Blenheim, Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. ..... 19..... (Date received by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945 at 5-15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 9 1945 to May 26 1945
and that I last saw him alive on May 26 1945

	DURATION
Immediate cause of death: Coronary Disease	24 hrs
Due to: Arteriosclerosis	Indefinite
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Burnett A. Sloan M. D. or other
Address: Lutherville Date signed: 5/26/45

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (7)

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

D4674

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Ft. Howard, Maryland

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2311 Frederick Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war WW-I

3. (a) FULL NAME HARRY AMEND

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife May Amend

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) 4-1-86

8. AGE: Years	Months	Days	If less than one day
59	1	27	hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name George L. Amend

13. Birthplace Balto., Md.

MOTHER 14. Maiden name Celia Gilmore

15. Birthplace Baltimore, Md.

16. Informant Clinical Records, Vets. Adm. Fac.
Address Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/2/45 (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery
Location Baltimore, Md.

18. Funeral director Wm. Cook Inc.
Address St. Paul & Preston Sts., Balto., Md.

19. 5/31 (Date rec'd by registrar) 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1945 19..., at 12:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 26, 1945, to May 29, 1945 and that I last saw him alive on May 29, 1945

Immediate cause of death	DURATION
Disease of the Heart;	7 Mos.
Hypertension, pulmonary with right	plus.
Due to Cardiac enlargement and Myocardial	
Insufficiency	
Due to Bronchitis, chr., asthmatic type	40 Yrs.
Other conditions Dilatation of the aorta.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. M. BALTER, LT. COL., M.C. M. CLIN. DIR.

Address Ft. Howard, Maryland Date signed 5-29-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

1

04675

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 17 days

Hospital, institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 4 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince Georges

City or town: Hyattsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4014 Nicholson Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles H. Anderson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Spearman

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): December 20, 1876

8. AGE: Years	Months	Days	If less than one day
68	4	24	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Plumber

11. Industry or business: Plumbing

FATHER
12. Name: Mason Victor Anderson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Amanda Young
15. Birthplace: Washington, D. C.

16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 14, 1945 (month) (day) (year)

Cemetery or crematory: Hyattsville

Location: Hyattsville Md.

18. Funeral director: Francis Leach Sons

Address: Hyattsville Maryland

19. 5/14/45 (Date rec'd by registrar) H. L. Andrews County Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 19 45, at 9:35 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 27 19 44, to May 14 19 45 and that I last saw him alive on May 14 19 45

Immediate cause of death	DURATION
Coronary occlusion	10 min.
Due to: Arteriosclerotic hypertensive cardiovascular disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Baltimore-28, Md. Date signed: 5/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-b)

CERTIFICATE OF DEATH

04676

Reg. Dist. No. 44

1. PLACE OF DEATH

County: Baltimore

City or town: Rosedale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Rosedale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8023 Old Philadelphia Road

(If rural, give LOCATION)

2.(a) If veteran, name war: NO

3.(a) FULL NAME Elizabeth Dorothy Baier

3.(b) Social Security Number NONE

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: John W Baier. Deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 13 1855

8. AGE: Years: 90 Months: 1 Days: 16 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore County

(Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business: AT HOME

FATHER 12. Name: Joseph Bruder.

13. Birthplace: Germany

MOTHER 14. Maiden name: Mary Bruder.

15. Birthplace: Germany

16. Informant: John H Baier

Address: 8023 Old Phila. Rd.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof JUNE 1/45 (month) (day) (year)

Cemetery or crematory: HOLY REDEEMER

Location: BELAIR ROAD

18. Funeral director: Lilly and Geiler INC.

Address: 403 S WOLFE ST.

19. 5/30 1945 (Date rec'd by registrar) A. A. Redmond M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945 at 11 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1945, to May 29 1945 and that I last saw h...r alive on May 29 1945

	DURATION
Immediate cause of death: Arteriosclerotic Heart Disease	15 yrs.
Due to:	
Due to:	
Other conditions: Chronic Nephritis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John C Baier M.D. M. D. or other

Address: 8 E Eastern Ave Date signed: May 29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04677

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Reisterstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 558 Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Helen W. Baker

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John A. Baker Sr.
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 17, 1877

8. AGE: Years	Months	Days	If less than one day
67	5	30	..... hrs. ..... min.

9. Birthplace: Balto. City
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: George D. Armiger
13. Birthplace: Md.

MOTHER
14. Maiden name: Agnes A. Henderson
15. Birthplace: Md.

16. Informant: John A. Baker Sr.
Address: Reisterstown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, 1945 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Balto. Co.

18. Funeral director: J. F. Eline & Sons
Address: Reisterstown, Md.

19. May 16 1945 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/13/45, 19..., at 9 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/31, 19..., to 5/13/45, 19...
and that I last saw her alive on 5/10/45, 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: hyper tension	
Due to: Arteriosclerosis	
Other conditions: Myocarditis.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James L. Lofted M. D. or other
Address: Reisterstown, Md. Date signed: 5/15/45

Evidence for change of year of birth of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

04678

FILM No. G 95 MAY 21 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:
County: Baltimore
City or town: Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Monkton (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hess Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ernest Edward Ball

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Sillie (nee Whitty)
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1888 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	7	4		

9. Birthplace: Anne Arundel Co, Md.
(Town, county, and state)
10. Usual occupation: Farmer.
11. Industry or business:

FATHER
12. Name: Wm. E. Ball
13. Birthplace: Anne Arundel Co, Md

MOTHER
14. Maiden name: Mary Russell
15. Birthplace: Anne Arundel Co, Md

16. Informant: Mrs. E. E. Ball
Address: Monkton, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 17 1945 (month) (day) (year)
Cemetery or crematory: St. Josephs
Location: Texas, Balto. Co. Md
18. Funeral director: Landon M. Broads
Address: Equals, Md.

19. May 14, 45 (Date rec'd by registrar) Wilmer C. Ensor, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1944, to May 14 1945
and that I last saw him alive on May 13 1945

Immediate cause of death	DURATION
Carcinoma (Gastric.)	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Two Gastro-enterostomies
Date of op.: 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer C. Ensor M.D. (M. D. or other)
Address: Cockeysville Md Date signed 5/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

04679

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 28 Yorkway
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Helen M Barrett

3.(b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Charles S
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Nov 1 1893

8. AGE: Years 51 Months 6 Days 25 If less than one day ... hrs. ... min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name John D Nugent
13. Birthplace Md
MOTHER 14. Maiden name Florence M Vinson
15. Birthplace Md
16. Informant Charles S Barrett
Address Dundalk Md
17. Burial Date thereof 5-29-45
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Cathedral Cem
Location George A Fuchs
18. Funeral director Fulton & Fawcett
Address Milton M Smilson
19. 5/28 1945 Milton M Smilson Local Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1945, at 4 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to May 26 1945
and that I last saw her alive on May 25 1945

	DURATION
Immediate cause of death Carcinoma of Colon	6-21-44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of the Colon
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Eugene F Nevy M.D.
M. D. or other
Address 7001 Mornington Rd Dundalk Md Date signed 5-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

04680

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 28 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No.: Reformed Church Home (If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Ida Barrick

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 30, 1858

8. AGE: Years	Months	Days	If less than one day
87	3	5	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER — 12. Name: George W. Barrick

13. Birthplace: ?

MOTHER — 14. Maiden name: Susan ?

15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8-1945 (month) (day) (year)

Cemetery or crematory: Mt Tabor Cem

Location: Rocky Ridge Md

18. Funeral director: M. L. Creager Son

Address: Thurmont Md

19. 5/5 1945 (Date rec'd by registrar) W. C. Anderson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5, 1945 at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1945, to May 5, 1945 and that I last saw her alive on May 5, 1945

	DURATION
Immediate cause of death: Chronic myocarditis	Indef.
Due to: Generalized arteriosclerosis	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Cirrhosis of liver, and Date of op.

Autopsy results? As above. Large gall bladder, stones.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Baltimore 28, Md. Date signed: 5/5/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

BC 1 04681

Reg. Dist. No. 30

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 14 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 year 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 South Castle Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Agnes Barron

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George Barron

Deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 21, 1872

8. AGE:	Years	Months	Days	If less than one day
	73	4	3	hrs. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER 12. Name: Stanislav Levinduski

13. Birthplace: Poland

MOTHER 14. Maiden name: Katherine - - -?

15. Birthplace: Poland

16. Informant: Hospital records, Spring Grove State

Address: Hospital, Catonsville, 28, Md.

17. Burial / (Burial, cremation, or removal. Which?) Date thereof May 28th 1945 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Rd.

18. Funeral director: John A. Moran

Address: 3000 E. Balto. St.

19. 5/26 1945 (Date rec'd by registrar) H. C. Rudisill Deputy Local Registrar

MEDICAL CERTIFICATION 1:20 pm

20. DATE OF DEATH: May 24, 1945 19 at [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 19 45 to May 24, 1945 and that I last saw her alive on May 24, 1945 19

	DURATION
Immediate cause of death: Chronic myocardial insufficiency	Indef
Due to: Arteriosclerotic Cardio vascular disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D.

Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

04682

P

CERTIFICATE OF DEATH

Reg. Diat. No. 41

1. PLACE OF DEATH:
County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 98 Shipway
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles H. Bates

3. (b) Social Security Number 218-01-9781

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mabel Marie
6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) July 21, 1890

8. AGE: Years 54 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Beth. Steel - Sparrows Point

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden name unknown
15. Birthplace unknown

16. Informant Mrs Wm A. Bates
Address 2532 Yorkway Dundalk
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/30/45 (month) (day) (year)
Cemetery or crematory Oaklawn
Location Eastern Ave
18. Funeral director John F Denny Inc.
Address 745 Light St. per G. L. Hess
19. 5/28 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26-45 19 4, at 12 00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ..., to ... 19 ..., and that I last saw h... alive on ... 19 ...

	DURATION
Immediate cause of death Coronary Occlusion	10 min
Due to Chronic Myocarditis	—
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE Chas. H. Davis M.D.
Asst Supt. Med. Exam. Bur. V. D. Control
Address Dundalk - Md. Date signed 5-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04683

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 9 months
Hospital, institution, or street address where death occurred: Spring Grove State Hospital
How long in hospital or institution? 4 years, 9 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Boeh

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Margaret ?
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1858

8. AGE:	Years	Months	Days	If less than one day
	87	1	27	hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Laborer - caretaker
11. Industry or business: Gardening
FATHER 12. Name: John Boeh
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Barbara Petsold
MOTHER 15. Birthplace: Germany
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Belair Rd.
18. Funeral director: Lilly-Zeiler Co.
Address: 408 S. Wolfe St
19. 5/14/45 (Date rec'd by registrar) Registrar: H. C. Andrews Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1945, at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13, 1940, to May 13, 1945, and that I last saw him alive on May 13, 1945.

	DURATION
Immediate cause of death: Terminal pneumonia	12 hrs.
Due to: Chronic myocardial insufficiency with arteriosclerotic	
Due to: cardiovascular disease	Indefinite
Other conditions: Acute exacerbation of chronic gall bladder dis. with stones.. (Include pregnancy within 3 months of death)	"

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other
Address: Catonsville, Balto.-28, Md. Date signed: 5/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

04684

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 409 S. Carolina Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME

EDWARD BOONE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Grace Boone

6.(c) If alive, give age: 42 years

7. Birth date of deceased (mo., day, yr.): July 4, 1889

8. AGE:	Years	Months	Days	If less than one day
	55	10	12	...hrs. ...min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: William Boone
13. Birthplace: ?

MOTHER
14. Maiden name: Mary ?
15. Birthplace: Washington, D.C.

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Elroy O. Wilson
Address: 1510 Orleans St., Balto., Md.

19. 5/19 (Date rec'd by registrar) 19 45 A. W. Hedrick Registrar
A.E.S.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945 at 5:00A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1945 to May 17, 1945 and that I last saw him alive on May 17, 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 Days plus
Due to: Hypertension, arterial	
Due to:	
Other conditions: Hemiplegia, right; Pneumonia and Arthritis, chr. (Include pregnancy within 3 months of death)	

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. M. Balter

A. M. BALTER, LT. COL., M.C. M. CLIN. DIR.

Address: Fort Howard, Md. Date signed: 5-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

04685

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: York Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret R. Bosley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife: Roy M. Bosley

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): July 28, 1912

8. AGE: Years	Months	Days	If less than one day
32	9	14	..... hrs. ..... min.

9. Birthplace: Glen Rock, Pa. (Town, county, and state)

10. Usual occupation: Homemaker

11. Industry or business: —

FATHER — 12. Name: George Moshoake

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Mazie Mechlley

15. Birthplace: Pennsylvania

16. Informant: Roy M. Bosley

Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14 1945 (month) (day) (year)

Cemetery or crematory: St. Pauls U. B. Church

Location: Balto. Co., Md.

18. Funeral director: Sanders M. Brooks

Address: Sparks, Md.

19. May 14, 19 45 Wilmer C. Ensor

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/11/45, 19..., at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/1/43, 19..., to 5/11/45, 19...

and that I last saw her alive on 5/11/45, 19...

Immediate cause of death	DURATION
Carcinoma of liver	6 months
Due to:	
Due to:	
Other conditions: metastasis	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James L. Gallell M. D. or other

Address: Reisterstown, Md. Date signed: 5/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

28
13
15

25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

04686

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas C. Bosley

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Emma Hale

6.(c) If alive, give age: 60? years

7. Birth date of deceased (mo., day, yr.): May 10, 1889

8. AGE: Years	Months	Days	If less than one day
56	-	21	...hrs. ...min.

9. Birthplace: Cockeysville, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER — 12. Name: Thomas Cole Bosley

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Alice R. Sanders

MOTHER — 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3, 1945 (month) (day) (year)

Cemetery or crematory: Bosley's.

Location: Sparks, md

18. Funeral director: Sanders M. Bowles

Address: Sparks, md.

19. (Date rec'd by registrar) 6/4 19 45 W. C. Gardner Registrar

Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 1945 at 6:35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to May 31 1945 and that I last saw him alive on May 31 1945

	DURATION
Immediate cause of death: Uremia	Indef.
Due to: Hypertensive cardiovascular disease	"
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

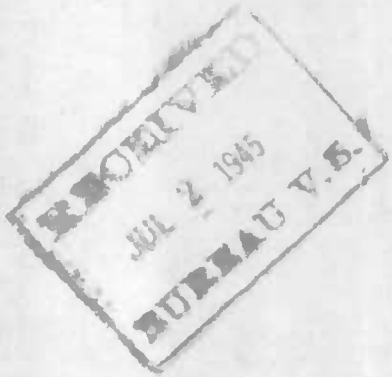
Robt. E. Gardner, M.D. M. D. or other

Address: Catonsville, -28, Md. Date signed 5/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
JUL 2 1945
BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

BC 04687

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

1001 K. St.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County ~~Balto~~

City or town Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1118 E Lombard St.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME David Boyd

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Susie Brown Boyd

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1893

8. AGE: Years	Months	Days	If less than one day
52			..... hrs. ..... min.

9. Birthplace Va (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business .....

FATHER 12. Name unknown

13. Birthplace ..

MOTHER 14. Maiden name unknown

15. Birthplace ..

16. Informant Susie B. Boyd

Address 1142 E Lombard St

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/45 (month) (day) (year)

Cemetery or crematory Mt. Calvary

Location .....

18. Funeral director Elroy O. Wilson

Address 1000 Brantley Ave

19. 5-16 1945 H.A. Holden

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945 at 8 30/a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 12 1945 and that I last saw h ..... alive on ..... 19 .....

Immediate cause of death	DURATION
Coronary Occlusion	Minutes
Due to	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. McLarnon M.D.

M. D. or other

Address Deputy Medical Examiner Dundalk, Md. Date signed 5-16-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (469)

CERTIFICATE OF DEATH

Reg. Dist. No. 0468830

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto
City or town: Owings Mills, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: James Branson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: Hattie
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 9, 1878

8. AGE: Years	Months	Days	If less than one day
66			hrs. min.

9. Birthplace: Owings Mills, Md. (Town, county, and state)
10. Usual occupation: Gardener
11. Industry or business
FATHER 12. Name: James Branson
FATHER 13. Birthplace: Owings Mills, Md.
MOTHER 14. Maiden name: Naomi Davis
MOTHER 15. Birthplace: Owings Mills, Md.
16. Informant: Anna Gamble
Address: 506 N. Carrollton Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5. 18. 1945 (month) (day) (year)
Cemetery or crematory: Western Star
Location: Balto Co. Md.
18. Funeral director: Wm. Law M. Cleveland
Address: 1631 Druid Hill Ave
19. 5/15/45 (Date rec'd by registrar) W. C. Andrews (Registrar) Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-14 19 45 at 1 30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-20- 19 44 to 5-14 19 45 and that I last saw him alive on 5-10 19 45

Immediate cause of death	DURATION
Carcinoma of Head of Pancreas	1 yr.?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Same as above. Date of op. Nov '44.
Autopsy results: None.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: None. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. D. Gapler, M.D. M. D. or other
Address: Reisterstown, Md. Date signed: 5-14-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1944
66
1678

Sept 25, 1850

04689

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 41

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 26 yrs
Hospital, institution, or street address where death occurred: 6762 Woodley Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6762 Woodley Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: George Robert Buell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married.

6.(b) Name of husband or wife: Martha V. Buell
6.(c) If alive, give age: 72 years
7. Birth date of deceased (mo., day, yr.): Nov. 17, 1875

8. AGE: Years	Months	Days	If less than one day
69	6	5	...hrs. ...min.

9. Birthplace: Baltimore Co., Md. (Town, county, and state)
10. Usual occupation: Crane operator
11. Industry or business: Beth. Steel
FATHER 12. Name: Melkhor Buell
13. Birthplace: Balto. Co., Md.
MOTHER 14. Maiden name: Elizabeth A. Thompson
15. Birthplace: Balto. Co., Md.
16. Informant: Martha V. Buell
Address: 6762 Woodley Road.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 25, 1945 (month) (day) (year)
Cemetery or crematory: Pine Grove
Location: Kingsville, Balto. Co., Md.
18. Funeral director: John F. Denny, Inc.
Address: 715 Light St.
19. 5/24 1945 (Date rec'd by registrar) D. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945 at 12:20 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 23, 1945 to May 22 1945 and that I last saw him alive on May 20 1945.

	DURATION
Immediate cause of death: Carcinomatosis	1 month.
Due to: Carcinoma liver	1 month.
Due to: Carcinoma stomach	4 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: David H. Anderson M.D. M. D. or other
Address: 2 Kenbrook Rd Dundalk Md. Date signed: 5/22/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 04690

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: BALTO.

City or town: GRAY MANOR (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 10 OAK WOOD ROAD

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 55 YEARS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MD. County: BALTO.

City or town: GRAY MANOR Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 10 OAK WOOD ROAD (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: NO

3. (a) FULL NAME: WALTER H. CARLL

3. (b) Social Security Number: 705-05-5114

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife: L. MABEL CARLL

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JAN. 24 1885

8. AGE: Years	Months	Days	If less than one day
60	3	20	hrs. min.

9. Birthplace: DANVILLE VA. (Town, county, and state)

10. Usual occupation: ENGINEER B & O RR.

11. Industry or business

FATHER — 12. Name: JOHN CARLL

FATHER — 13. Birthplace: VA.

MOTHER — 14. Maiden name: UNKNOWN

MOTHER — 15. Birthplace: VA.

16. Informant: L. MABEL CARLL (WIFE)

Address: 10 OAK WOOD ROAD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: MAY 17/45 (month) (day) (year)

Cemetery or crematory: OAK LAWN

Location: EASTERN AVE. EXT.

18. Funeral director: Lilly and Geiler INC.

Address: 403 S. WOLFE ST.

19. MAY 17 19 45 (Date rec'd by registrar) John A. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MAY 14 1945, at 8/30 PM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15th 1945, to May 14 1945, and that I last saw him alive on May 14th 1945.

Immediate cause of death: Cardio-Vascular-Renal disease — DURATION: 2 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: no

Of autopsy: no

PHYSICIAN — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James McNitt M.D. M. D. or other

Address: 7601 Eastern Ave., Baltimore 24, Md. Date signed: 5/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

04691

Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 605 Coleraine Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Annie M. Chairs

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Widow

6.(b) Name of husband or wife: Late Samuel W. Chairs
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 16, 1869

8. AGE: Years: 75 | Months: 7 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: Charles Linstid
13. Birthplace: Md

MOTHER
14. Maiden name: Unknown
15. Birthplace: Md

16. Informant: Mrs. Albert C. Kunkel
Address: 605 Coleraine Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9 1945 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Brooklyn — A.A. Co. Md.

18. Funeral director: Harry H. Nuttle
Address: 4101 E. Monument Ave.

19. 5-9-45 (Date rec'd by registrar) 19 ... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7/45 19... at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July - 1 19 40, to May - 7 19 45
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Arterial Hypertension & Cerebral Hemorrhage	5 yrs / ½ yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: No.
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. Lloyd Johnson M. D. or other
Address: Catonsville, Md. Date signed: 5-8-45

Mr. D. F. Johnson
610 Field Rd
Cat 845

M

04692

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 44

VS A15 — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Balto.
City or town Essex (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Island Pt. Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto.
City or town Essex (If outside city or town limits, write RURAL and give nearest town)
Street No. Island Pt. Rd. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Frederick Collins

3. (b) Social Security Number

4. Sex M
5. Color or race W
6.(a) Single, married, widowed, or divorced: divorced
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Feb 16 - 1878

8. AGE: Years 67 Months Days If less than one day ... hrs. ... min.

9. Birthplace Wheeling W. Va. (Town, county, and state)
10. Usual occupation Boatman
11. Industry or business Own
FATHER 12. Name Samuel A Collins
13. Birthplace Unk.
MOTHER 14. Maiden name Ada B. Hane
15. Birthplace Unk.
16. Informant Mrs Winifred Beetham
Address 2911 E. Balto St.
17. Burial Date thereof 5/8/45 (month) (day) (year) (Burial, cremation, or removal. Which?)
Cemetery or crematory Balto.
Location North Ave.
18. Funeral director John G. Connelly
Address 418 Eastern Ave. Essex 21
19. May 7th 1945 Jhn G. Connelly
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 4 1945, at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 4 1945, to May 4 1945
and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Occlusion — DURATION: Immediate
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. M. McCarroune M.D. Deputy Med. Examiner (M. D. or other)
Address Dundalk Md. Date signed 5/4/45

1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

04693

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: County: Baltimore Co. Catonsville Md.

City or town: (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred: Catonsville Convalescent Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 32 N. Ellamont St (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Helen A Coat

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George J.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November - 4 - 1864

8. AGE: Years: 80 Months: Days: If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Enoch Spalding

13. Birthplace: Wash. D.C.

MOTHER — 14. Maiden name: Helen A Pitts

15. Birthplace: Wash. D.C.

16. Informant: Horace J. Coat

Address: 32 N. Ellamont St

17. Burial, cremation, or removal. (Which?) Burial Date thereof: 5 - 28 - 45 (month) (day) (year)

Cemetery or crematory: Oak Hill Cem

Location: 30th & Pitts N.W. Wash. D.C.

18. Funeral director: Thos. E. Miller Inc.

Address: 2435 E. Oliver St

19. 5/26/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 19 45, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 19 45, to May 24 19 45

and that I last saw h.. alive on May 24 19 45

Immediate cause of death	DURATION
Arteriosclerotic cardiovascular heart disease	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroat causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Jean A. Kohlman, M.D. M. D. or other

Address: Ellicott City Md. Date signed: 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

State Health
Permit - Transcript

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04694

Reg. Dist. No. 40

1. PLACE OF DEATH:

County: Baltimore

City or town: Glen Arm P.O. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months

Hospital, institution, or street address where death occurred:
Manor Road

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Glen Arm P.O. (Rural)
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Manor Road
(If rural, give LOCATION)

2.(a) If veteran, name war: **********

3. (a) FULL NAME

CECELIA O'CONOR CROSS

3. (b) Social Security Number
****

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William C. Cross

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): November 15, 1871

8. AGE: Years	Months	Days	If less than one day
73	6	16	..... hrs. ..... min.

9. Birthplace: Baltimore County, Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Hugh O'Conor
13. Birthplace: Maryland

MOTHER
14. Maiden name: Bridget Fahey
15. Birthplace: Ireland

16. Informant: Mrs. Elizabeth C. Watson
Address: Glen Arm, Balto. Co., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Maria Cemetery

Location: Towson, Maryland

18. Funeral director: John Burns' Sons

Address: Towson, Maryland

19. 5/30/45 (Date rec'd by registrar) 19.....

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29, 1945, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1942, to May 29, 1945; and that I last saw h[illegible] alive on May 26 1945.

	DURATION
Immediate cause of death: Myocarditis, chronic, with decompensation	5 yrs +
Due to: Heart disease, valvular, mitral	Unk
Due to: Hypertension & Arteriosclerosis	Unk Unk
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Rollin L. Hudson M.D.
M. D. or other

Address: Towson 4 Md. Date signed: 5/30/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for addition of place of death is shown on FILM No. G95 JUN 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

04695

Reg. Dist. No. 38

1. PLACE OF DEATH: Balto. Md.

County

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 510 W. Chesepeake Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 510 W. Chesepeake Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Eli Scott Dance

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 5 - 1843

8. AGE:

Years	Months	Days	If less than one day
102	4		..... hrs. ..... min.

9. Birthplace: Lochraven Balto Co. Md.

(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Joseph B. Dance

13. Birthplace: Penna

MOTHER — 14. Maiden name: Mary Dunkerson

15. Birthplace: Penna

16. Informant: Geo. E. Baird

Address: 510 Chesapeake Av.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 10-1945 (month) (day) (year)

Cemetery or crematory: Old School Baptist Cem.

Location: Near Jarrettsville

18. Funeral director: Clarence E. Arthur

Address: Bel Air Md.

19. May 9 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 45 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 15 19 45 to May 7 19 45

and that I last saw him alive on May 7 19 45

Immediate cause of death	DURATION
Peripheral Circulatory Failure	4 hours
Due to: Arterio Sclerotic Heart Disease	chr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Chas. Keller M. D. M. D. or other

Address: Towson Md. Date signed: 5/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (183)

Registered No. 44

04696

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore City, Maryland Balto. Co.
(b) Street address Coast
(c) Hospital or institution #1.
Glenn L. Martin, Coast Guard Station
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) 2 MONS.

2. USUAL RESIDENCE OF DECEASED:
(a) State Virginia (b) County
(c) City or town Richmond.
(If outside city or town limits, write RURAL and give town)
(d) Street No. R.F.D #9.
(If rural give location)
(e) Citizen of foreign country? (Yea or No)
If yes, name country

3 (a) FULL NAME Sgt. Randolph G. Darkiell

3 (b) If veteran, name war: # 2 W.W.

3 (c) Social Security Account No.: ?

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1924

8. AGE: Years 21 | Months | Days | If less than one day hr. min.

9. Birthplace VIRGINIA
(Town, county, and state)

10. Usual Occupation U.S. Army.

11. Industry or business 1304. S.C.U.

FATHER
12. Name UNKNOWN
13. Birthplace UNKNOWN

MOTHER
14. Maiden Name UNKNOWN
15. Birthplace UNKNOWN

16 (a) Informant ARMY RECDS.
(b) Address CAMP HOLIBIRD

17 (a) BURIAL (b) Date thereof MAY 31/45
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory RICHMOND VA.
Location VA.

18 (a) Funeral director Lilly and Zeuler INC
(b) Address 403 S. WOLFE ST.

19 (a) 5/28/45 (b)
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 8:00 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained
Autopsy, Inspection or Inquiry
by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑ suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH drowning

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury May at 18, 1945 M.
(b) Where did injury occur? Chesapeake Bay
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Drowned while out sailing

Signature Howard J. Thuesen M.D.
Medical Examiner.
Date signed May 28, 1945

VS 151

Evidence for change of year of birth of deceased is as shown on FILM No. G 95 MAY 26 1945

04697 T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Balto.
City or town: Raspeburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Raspeburg (If outside city or town limits, write RURAL and give nearest town)
Street No.: Rosewick Ave (If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Charles Dorbert

3. (b) Social Security Number: 218-07-0696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Elizabeth Dorbert
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 6th 1880 ~~1886~~

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
58	11	28		

9. Birthplace: Balto. Md. (Town, county, and state)
10. Usual occupation: Pensioned
11. Industry or business: U. S. War Veteran
FATHER 12. Name: Geo. F. Dorbert
13. Birthplace: Balto. Md.
MOTHER 14. Maiden name: Josephine Sudhausen
15. Birthplace: Balto. Md.
16. Informant: Geo. P. Dorbert
Address: Rosewick Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 8 45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Balto. Md.
18. Funeral director: Lansdale Funeral Home
Address: 7401 Belair Rd.
19. 5/7/45 (Date rec'd by registrar) 19 ..... Mrs. G. L. Reynolds Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4th 1945, at 3:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1945 to May 4 1945 and that I last saw him alive on May 4 1945

Immediate cause of death	DURATION
Tuberculosis of the lungs far advanced	8 wks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Falesci M D (M. D. or other)
Address: 6217 Harford Rd Date signed: 5/5/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

T 04698

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:
615 Eastern Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Essex
(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 Eastern Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

KATIE DRYER

3. (b) Social Security Number

***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Wm. Dryer

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 16, 1880

8. AGE: Years	Months	Days	If less than one day
65	2	21	____ hrs. ____ min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Louis Engle

Address: 615 Eastern Ave.

17. burial (Burial, cremation, or removal. Which?) Date thereof: May 10, 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Chase, Md.

18. Funeral director: Loane-Lw Funeral Home

Address: 7401 Belair Road

19. 5-8-45 (Date rec'd by registrar) John G. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7th, 1945 at 11:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1942 to May 7 1945 and that I last saw her alive on May 7 1945

	DURATION
Immediate cause of death: Coronary Occlusion	4 hours
Due to: Arteriosclerotic Heart Dis.	10 yr.
Due to:	
Other conditions: Diabetes Mellitus	2 yr.
Pernicious Anemia	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: John C Baier MD (M. D. or other)

Address: 815 Eastern Ave Date signed: 5-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (94a)

Registered No. P 04099

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 2810 Oakcrest Ave

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland County

(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)

(d) Street No. 2810 Oakcrest Ave
(If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) **FULL NAME** Harry P. Edwards

3 (b) If veteran, name war —

3 (c) Social Security Account No. 213-05-8585

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	Married

6 (b) Name of husband or wife Nona C.

6 (c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) June 25 1902

8. AGE: Years	Months	Days	If less than one day
42	10	8	hr. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual Occupation Asst Manager

11. Industry or business of Theater

FATHER
12. Name Harry P. Edwards Sr.
13. Birthplace Baltimore Md.

MOTHER
14. Maiden Name Margaret Reynolds
15. Birthplace Baltimore Md.

16 (a) Informant Mrs Nona C. Edwards
(b) Address 2810 Oakcrest Ave

17 (a) Funeral Burial (b) Date thereof 5/4/45
(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Roseland Cem.
Location Reedsville Va.

18 (a) Funeral director Leonard J. Ruck

(b) Address 5305 Harford Rd

19 (a) MAY 4 1945 (b) Huntington Williams, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 19 45, at 3:05 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 13 19 44, to May 3 19 45, and that I last saw him alive on May 3 19 45

Immediate cause of death	Duration
Coronary Thrombosis	
Due to Bronchitis	
Due to Myocarditis	
Due to Duodenal Ulcer	
Other Conditions Ulceration, Colitis	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Richard Jones M.D.

Address 5305 Harford Rd Date signed May 5 1945

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, hut are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-6)

CERTIFICATE OF DEATH

04700

Reg. Diat. No. #32

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1b

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 0 mos., 16 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium

How long in hospital or institution? 0 yrs., 0 mos., 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Essex (If outside city or town limits, write RURAL and give nearest town)

Street No.: 261 Edgewater Apts. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Helen Embert

3.(b) Social Security Number: 214-22-7121

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Paul Embert

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): May 6, 1901

8. AGE: Years	Months	Days	If less than one day
44	0	4	...hrs. ...min.

9. Birthplace: Easton, Maryland (Town, county, and state)

10. Usual occupation: Registered Nurse

11. Industry or business:

FATHER — 12. Name: Geo. W. Fluharty

13. Birthplace: Easton, Maryland

MOTHER — 14. Maiden name: Elizabeth Frampton

15. Birthplace: Maryland

16. Informant: Mrs. Helen Embert

Address: 261 Edgewater Apts., Essex, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12, 1945 (month) (day) (year)

Cemetery or crematory: Silver Hill Cemetery

Location: Easton, Maryland

18. Funeral director: Ellis Clark

Address: Easton, Maryland

19. May 10, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1945, at 5:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 24, 1945, to May 10, 1945 and that I last saw her alive on May 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	2 yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Enteritis, Unknown Tuberculosis of Vulva & Vagina; Vagino-Rectal Fistula. (Include pregnancy within 3 months of death)	

Major findings of operations: ...Date of op.: ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ... Injured at work?

23. SIGNATURE: Stewart S. Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed: 5/10/45

Certified by Dr. S. S. Nichols 5-15-45

P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

04701

Reg. Dist. No. 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort. Howard.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life.

Hospital, institution, or street address where death occurred:

Todd Abe.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Dist. Ft.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John William Ewing. Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 30. 1944.

8. AGE: Years | Months: 10 | Days: 18 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Fort. Howard. Md.
(Town, county, and state)

10. Usual occupation: none.

11. Industry or business

FATHER 12. Name: John Tone Ewing.

FATHER 13. Birthplace: Comorg. Va

MOTHER 14. Maiden name: Mary P. Benvenga

MOTHER 15. Birthplace: Balto. md.

16. Informant: Mary. Ewing - mother

Address: as in #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/19/45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Rd & Moravia Ave.

18. Funeral director: Frank Della Noce

Address: 52 N. Morley St. Balto

19. 5/19 1945 Wm. J. Hedrick Registrar
(Date rec'd by registrar) S.M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May. 18 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945 to May. 18 1945 and that I last saw him alive on May. 18 1945.

	DURATION
Immediate cause of death: acute Broncho Pneumonia	6 hours.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis N. Tollin. M.D. M. D. or other

Address: Sparrows Point Md Date signed 5/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

T

2-Y-'30 04702

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 14 days

Hospital, Institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Street

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Stewart F. Famous

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: Jennie Taylor

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 9, 1864

8. AGE: Years	Months	Days	If less than one day
80	9	10	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: retired merchant

11. Industry or business: small store

FATHER — 12. Name: Samuel Famous

13. Birthplace: ?

MOTHER — 14. Maiden name: Mary Hornburger

15. Birthplace: ?

16. Informant: Hospital Records

Address: Catonsville-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-22-45 (month) (day) (year)

Cemetery or crematory: Green Mount Cemetery

Location: York Pa.

18. Funeral director: Stpack & Stine Funeral Home

Address: York Pa.

19. 5/19 19 45 (Date rec'd by registrar) H. C. Landvogt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19 19 45 at 7:30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5, 19 45, to May 19 19 45

and that I last saw him alive on May 19 19 45

	DURATION
Immediate cause of death: Broncho-pneumonia	2 days
Due to: Hypertensive Cardiovascular Renal Disease.	Indef.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M. D.

Robert E. Gardner M. D. or other

Address: Catonsville-28, Md. Date signed 5/19/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

04703

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2300 Rockwell Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Katie A.Fischer

3. (b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Wht.	Widow

6.(b) Name of husband or wife: Albert F.Fischer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1865

8. AGE: Years	Months	Days	If less than one day
79	7	16	hrs. min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business
FATHER 12. Name: Louis Bode
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Unknown
MOTHER 15. Birthplace: Germany
16. Informant: Mrs. Edna F. Daum
Address: 2300 Rockwell Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7, 1945 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Balto. Md.
18. Funeral director: Robert S. Little
Address: 2700 Edmondson Ave.
19. 5/5/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 45, at P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 20 19 30, to May 4 19 45
and that I last saw h.er alive on Apr. 30 19 45

Immediate cause of death	DURATION
Coronary Embolism	1 hr.?
Due to: Generalized Arterio-Sclerosis	15 yrs.
Due to: Hypertension	15 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Roger Elston MD M. D. or other
Address: 803 3rd Ave Catonsville 28 Md. Date signed: 5-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

64764

Reg. Diat. No. .....

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or towe: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 170 Allegheny Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No.

3.(a) FULL NAME: Margaret L. Ford

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Horace Ford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 3, 1879

8. AGE: Years	Months	Days	If less than one day
65	10	6	..... hrs. ..... min.

9. Birthplace: Baltimore Md.
(Town, county, and State)

10. Usual occupation: Homemaker

11. Industry or business

FATHER
12. Name: J. George Sanstee
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Bertha Riepenhoff
15. Birthplace: Balto. Md.

16. Informant: Mrs. V. C. Roberts
Address: 170 Allegheny Ave, Towson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1945 (month) (day) (year)
Cemetery or cremstory: Parkwood
Location: E. Taylor Ave. Balto, Md.

18. Funeral director: Sanders M. Brooks
Address: Govans, Md.

19. May 10 1945 (Date rec'd by registrar) Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 '45 19..... at 3:P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 1 1944 to May 8 1945 and that I last saw h.. alive on May 5 1945

Immediate cause of death	DURATION
Carcinoma (Pancreas)	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma (Pancreas)
Date of op. Feb 1944

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Hunt Guest M.D.
M. D. or other
Address: Towson - Md. Date signed 5/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

04705

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Balto.

City or town Rockdale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

8201 Rockdale Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Rockdale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8201 Rockdale Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME THOMAS STOCKDALE FORWOOD

3.(b) Social Security Number 212-10-0896

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Julia L. Forwood

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 8, 1877

8. AGE: Years	Months	Days	If less than one day
67	6	2	..... hrs. ..... min.

9. Birthplace Balto. Co., Md. (Town, county, and state)

10. Usual occupation Ass't. Mgr. Fiscal Agency

11. Industry or business Federal Reserve Bank

FATHER 12. Name Samuel Edward Forwood

13. Birthplace Harford Co., Md.

MOTHER 14. Maiden name Meral Greene

15. Birthplace Balto., Md.

16. Informant Mrs. Julia L. Forwood

Address 8201 Rockdale Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/45 (month) (day) (year)

Cemetery or crematory Chester Cem.

Location Chestertown, Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 5/12 19 45 [signature] Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10, 19 45 at 10:35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9 19 45 to May 10 19 45

and that I last saw ..... alive on May 10 19 45

	DURATION
Immediate cause of death Coronary Thrombosis	3 days
Due to Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thos J Eckard M. D. or other

Address 4509 Liberty Hgts. Ave Date signed 5/11/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (143-4)

CERTIFICATE OF DEATH

04706 P

Reg. Diat. No.....

1. PLACE OF DEATH

County Baltimore

City or town Ruxton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:
Own Home, Malvern Ave. Ruxton

How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Ruxton
(If outside city or town limits, write RURAL and give nearest town)

Street No. Malvern Ave
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3.(a) FULL NAME Eleanor Willis Fox

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband George D. Fox

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) Oct 31st 1903

8. AGE: Years	Months	Days	If less than one day
41	6	15	.....hrs. .....min.

9. Birthplace Church Creek Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER
12. Name William T. Willis
13. Birthplace Md.

MOTHER
14. Maiden name Cina Neild
15. Birthplace Md.

16. Informant George D. Fox
Address Malvern Ave - Ruxton

17. Removal Date thereof 5/17/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery ~~or crematory~~ Old Trinity

Location Church Creek Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. 5/17 45 H.W. Hedrick D.M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 6.50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from [illegible] 19..... to.....19.....

and that I last saw h..... alive on.....19.....

	DURATION
Immediate cause of death Sodium fluoride poisoning (Self administered ant paint)	5/16/45
Due to Psychosis with depressions (Phipps Clinic, Hopkins 1934)	1934 +
Due to.....	
Other conditions.....	

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op.....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of May 16, 1945

Where did injury occur? Ruxton (City or town) Baltimore (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury..... Injured at work?

23. SIGNATURE Rollin E. Hudson M.D. DME
M. D. or other

Address Towson 4, Md Date signed 5/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

D C4707 P

Reg. Dist. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 56 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 56 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 3118 Chesley Ave (If rural, give LOCATION)

2.(a) If veteran, name war SAW

3. (a) FULL NAME LAWRENCE H. FRANCIS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of ~~husband~~ wife Mrs. Martha V. Francis

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) 7-15-78

8. AGE: Years	Months	Days	If less than one day
66	9	28	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER — 12. Name Charles Francis

13. Birthplace Maryland

MOTHER — 14. Maiden name Mary Anne Torbit

15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Fac.

Address Fort Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1945 (month) (day) (year)

Cemetery or crematory Prospect Hill Cem.

Location Towson, Md.

18. Funeral director John Burns' Sons

Address Towson, Md.

19. 5 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 14, 1945, 19..., at 2:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1945, to May 14, 1945 and that I last saw him alive on May 14, 1945

Immediate cause of death	DURATION
Coronary Arteriosclerosis	2 Yrs.
Due to Myocardial damage, Myocardial Insufficiency	plus
Due to	
Other conditions Nephritis, interstitial, chr.	

(Include pregnancy within 3 months of death)

Major findings of operation .....Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE A.M. Balter

A.M. BALTER, LT.COL., M.C. CLIN. DIR.

Address Fort Howard, Md. Date signed 5-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04708

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Balto.

City or town (Rural) Cockeysville Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: (Ashland)

Stay in hospital or insf. (yrs., or mos., or days) Lifetime

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Balto

City or town Cockeysville (Rural) (If outside city or town limits, write RURAL NEAR and give town)

Street No. (Ashland) (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Laura Naomi Freeland

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married.

6 (b) Name of husband or wife Daniel E. Freeland.

6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Nov 11 1871.

8. AGE: Years	Months	Days	If less than one day
73	6	13	____hrs. ____min.

9. Birthplace Monkton Md. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business Home.

FATHER 12. Name Wm Tracy.

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace

16. Informant Daniel Freeland. Address Cockeysville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27, 1945 (month) (day) (year)

Cemetery or crematory Poplar

Location Cockeysville, Md (Rural)

18. Funeral director Landon M. Brooks

Address Govds, Md.

19. May 25 1945 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945, at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1944, to May 24 1945, and that I last saw h er alive on May 23 1945.

Immediate cause of death	DURATION
Carcinoma. (Intestinal.)	5 yrs.
Due to	
Due to	
Other conditions Myocarditis.	2 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations Abdomial Opns. - 1940. (City Hosp.)

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Wilmer C. Ensor M.D. M. D. or other

Address Cockeysville Md Date signed 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04709

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Balto
City or town: Raspeling
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 42 years
Hospital, institution, or street address where death occurred:
4311 Belvian Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Raspeling
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4311 Belvian Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Lena Frei

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Frei
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 11/24/69

8. AGE: Years: 75 | Months: 5 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Switzerland (town, county, and state)

10. Usual occupation: at home

11. Industry or business

FATHER
12. Name: Nicholas Ramseyer
13. Birthplace: Switzerland

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Nicholas Ramseyer
Address: Raspeling, Md.

17. Burial, cremation, or removal. Which?: Burial — Date thereof: 5 20 45 (month) (day) (year)
Cemetery or crematory: Immanuel Luth.
Location: Balto Md.

18. Funeral director: Lansdale Funeral Home
Address: 7401 Belair Rd.

19. (Date rec'd by registrar): May 19 19 45 — Registrar: mrs. Reifsneider

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14th 19 45 at 9:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16 19 43 to May 14 19 45
and that I last saw h[er] alive on 5-17 19 45

Immediate cause of death	DURATION
Cardiac Asthma	
Due to: Hypertension & arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Victor Ramseyer M.D.
M. D. or other
Address: 7401 Belair Rd. Date signed: 5-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

M

B.C.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (129)

CERTIFICATE OF DEATH

04710 Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Hrs. 45 Min.

Hospital, institution, or street address where death occurred: Vets. Adm. Fac. Ft. Howard, Maryland

How long in hospital or institution? 11 Hrs. 45 Min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 2519 N. Calvert St. (If rural, give LOCATION)

2.(a) If veteran, name war None

3.(a) FULL NAME HARVEY M. FREY

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Lilly Frey

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.) 4-1-~~85~~ 1885

8. AGE: Years	Months	Days	If less than one day
60 ~~65~~	1	~~24~~ 15	.... hrs. .... min.

9. Birthplace Baltimore, Maryland (Town, county, and state)

10. Usual occupation ?

11. Industry or business

FATHER 12. Name FRANK M. FREY

13. Birthplace BALTIMORE, MARYLAND

MOTHER 14. Maiden name ELIZABETH S. Fay

15. Birthplace BALTIMORE, MARYLAND

16. Informant Mrs John F. Stevenson (Sister)

Address 209 Murdock Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18-1945 (month) (day) (year)

Cemetery ~~or crematory~~ Baltimore

Location Baltimore, Md

18. Funeral director Wm. J. Tickner & Sons

Address North & Penn. Aves., Balto., Md.

19. 5/18 19 45 A-W Hedrick D.M. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16, 19 45, at 12:50A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15, 19 45, to May 16, 19 45 and that I last saw him alive on May 16, 19 45

Immediate cause of death Generalized Peritonitis

DURATION

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above 5/16/45

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

J.B.

23. SIGNATURE M. B. Davis M.D. M. D. or other

Asst. Chf. Med. Exam. - Pracd.

Address Dividanc - ?? - Hy Date signed 5/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (83-D) Reg. Dist. No. 4713 / 6171

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Baltimore

(b) City or town Randallstown (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Liberty Road

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Randallstown (If outside city or town limits, write RURAL and give town)

(d) Street No. Liberty Road (If rural give location)

(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** Harriett Ann Fryfogle

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	White	Married

6 (b) Name of husband or wife Alfred C. Fryfogle

6. (c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) June 17, 1890

8. AGE: Years	Months	Days	If less than one day
54	11	6	____ hr. ____ min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER

12. Name Charles Hoffman

13. Birthplace Baltimore, Md.

MOTHER

14. Maiden Name Ella McGinnis

15. Birthplace Rockdale, Md.

16 (a) Informant Mr. Alfred C. Fryfogle

(b) Address Liberty Rd., Randallstown

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 26, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18 (a) Funeral director Miller Donovan

(b) Address 4510 Liberty Heights Ave.

19 (a) 5/22/45 (Date rec'd by registrar) (b) Wm. E. Martus Registrar

MEDICAL CERTIFICATION

20. Date of death May 23 1945, at 5 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 20 1945, to May 23 1945 and that I last saw her alive on May 22, 1945.

Immediate cause of death	Duration
Cerebral Hemorrhage	3 days
Due to Arteriosclerosis &	
Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Wm. E. Martus M. D. or other

Address Randallstown, Harrisonville, Md. Date signed 5/23/45

VS. A15 (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

04712 (B3)
Reg. Diat. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, Institution, or street address where death occurred: Hood's Nursing Home
How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Sara Scrivner Gantt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Geo B. Gantt
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) ~~Oct~~ 1867

8. AGE: Years	Months	Days	If less than one day
78			hrs. min.

9. Birthplace: Anne Arundel Co.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Wm B Scrivner
13. Birthplace: Md.

MOTHER
14. Maiden name: Sara Barberg
15. Birthplace: Md.

16. Informant: Nearest Kin
Address: 5313 Edmondson Av

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 6 1945 (month) (day) (year)
Cemetery or crematory: All Saints
Location: Sandyland Md
18. Funeral director: F. C. Haubert & Son
Address: Gabrielle Md

19. 5/6 1945 (Date rec'd by registrar) F. C. Haubert Deputy Coroner (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1945 at 8:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 29 1945, to May 6 1945 and that I last saw h.. alive on May 6 1945

Immediate cause of death	DURATION
Chr. Myocarditis	1 yr
Due to Generalized Arteriosclerosis	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Irene Stowers M. D. or other
Address: Catonsville Date signed 5-6-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 04713

P

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 Days
Hospital, Institution, or street address where death occurred:
Vets. Administration Fac. Fort Howard, Md.
How long in hospital or institution? 19 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1337 Gay Street (If rural, give LOCATION)
2.(a) If veteran, name war: SAW

3.(a) FULL NAME: CHARLES GARDENER (Gardner)

3.(b) Social Security Number: 214-24-5406

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Widowed
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 5-1-74

8. AGE: Years	Months	Days	If less than one day
71		8	..... hrs. ..... min.

9. Birthplace: Syracuse, New York (Town, county, and state)
10. Usual occupation: Chauffeur
11. Industry or business
FATHER 12. Name: George Gardener
13. Birthplace: ?
MOTHER 14. Maiden name: Lennah Schroeder
15. Birthplace: ?
16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland
18. Funeral director: Phillip Herwig Sons
Address: 2024 Orleans St., Baltimore, Md.
19. 5/14/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 10, 1945 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21, 1945 to May 10, 1945 and that I last saw him alive on May 10, 1945

Immediate cause of death	DURATION
Lobular- Pneumonia	3 Days
Due to	
Due to	
Other conditions: Syphilis of Central Nervous system, meningo-vascular type (2911) (Include pregnancy within 3 months of death)	

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C. CLIN. DIR
Address: Fort Howard, Maryland Date signed: 5-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC T 04714

Reg. Diat. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mount Wilson, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 0 yrs., 4 mos., 26 days

Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Maryland Tuberculosis San.

How long in hospital or institution? 0 yrs., 4 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4252 Shamrock Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph P. Gorski

3.(b) Social Security Number: 262-09-2706

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Genevieve M. Gorski 6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): February 19, 1905

8. AGE: Years	Months	Days	If less than one day
40	3	9	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business:

FATHER — 12. Name: Julious Gorski; 13. Birthplace: Poland

MOTHER — 14. Maiden name: Sally Grzykowski; 15. Birthplace: Poland

16. Informant: Joseph P. Gorski

Address: 4252 Shamrock Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31, 1945 (month) (day) (year)

Cemetery or crematory: Holy Redeemer Cemetery

Location: Baltimore, Maryland

18. Funeral director: Marie Fialkowski, Inc.

Address: 1100 S. Kenwood Ave., Balto., Md.

19. May 28, 1945 (Date rec'd by registrar) Earl T Webster Registrar

MEDICAL CERTIFICATION

A.M

20. DATE OF DEATH: May 28, 1945, at 10:40 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 2, 1945, to May 28, 1945 and that I last saw him alive on May 28, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	5 Yrs. 9 Mos.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	9 Mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: None - No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Stewart S Shaffer M.D. M. D. or other

Address: Mount Wilson, Md. Date signed: 5/28/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (467)

CERTIFICATE OF DEATH

BC

04715

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs., 15 mos., 22 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 13 yrs., 15 mos., 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3005 Littleton Rd., Walbrook
(If rural, give LOCATION)

2.(a) If veteran, name war: Y

3. (a) FULL NAME: Nannie Gossett

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Separated

6.(b) Name of husband or wife: John E. Gossett

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 3, 1875

8. AGE: Years	Months	Days	If less than one day
69	7	1	hrs. min.

9. Birthplace: Camden, South Carolina
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Home

FATHER
12. Name: Jacob Anderson
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Nancy Williams
15. Birthplace: South Carolina

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/5/45 (month) (day) (year)

Cemetery or crematory: Loudon Park

Location: Balto. Md.

18. Funeral director: William Cook Inc

Address: 1217 St. Paul St.

19. 5/5 45 (Date rec'd by registrar) A. W. Hedrick (Signature of Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 19 45 at 2:05 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 12 19 45, to May 4 19 45 and that I last saw her alive on May 4 19 45

	DURATION
Immediate cause of death: Cachexia	1 month
Due to: Carcinoma of the rectum	18 mos.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BC T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

Reg. Dist. No. 31

Cert. No. 04716

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months 13 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 10 months 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 428 West Cross St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Greshner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none

6.(c) If alive, give age: yeare

7. Birth date of deceased (mo., day, yr.): September 19, 1866

8. AGE: Years	Months	Days	If less than one day
78	7	26	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -------

FATHER — 12. Name: Unknown

13. Birthplace: W

MOTHER — 14. Maiden name: Susan ---?

15. Birthplace: Unknown

16. Informant: Hospital Records, Spring Grove State Hospital, Catonsville, 28, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18-45 (month) (day) (year)

Cemetery or crematory: Western

Location: Balto, Md.

16. Funeral director: Flynn & Fleming

Address: 1426 Light St.

19. 5/17 (Date rec'd by registrar) 19 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 45 at 5:25 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1944 19 to May 15 19 45 and that I last saw h im alive on May 15 1945 19

Immediate cause of death	DURATION
Erysipelas	10 da
Due to: Hypertensive Cardio-renal disease	Indefinit
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. Mead, M.D. M. D. or other

Henry C. Mead, M. D.

Address: Catonsville, 28, Md. Date signed: 5/15/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

04717

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 23 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 1 month, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If ontside city or town limits, write RURAL and give nearest town)

Street No. 1606 Linden Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME: Jacob Grimsey

3.(b) Social Security Number: --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife: Jenny Rudick Grimsey

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 10, 1868

8. AGE: Years	Months	Days	If less than one day
76	10	23	...hrs. ...min.

9. Birthplace: Pennsylvania (Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: For Mr. Berman

FATHER
12. Name: William Grimsey
13. Birthplace: Ireland

MOTHER
14. Maiden name: Sarah Elizabeth Johnson
15. Birthplace: England

18. Informant: Hospital records

Address: Catonsville, Baltimore - 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/45 (month) (day) (year)

Cemetery or crematory: St. Peters Cem.

Location: Baltimore, Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5-5-45 (Date rec'd by Registrar) 19 45 Registrar [signature] Address [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 19 45 at 7:40 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 10, 19 45, to May 3, 19 45 and that I last saw h... im ...alive on May 3, 19 45

	DURATION
Immediate cause of death: Coronary thrombosis	1 day
Due to: Chronic hypertensive cardiovascular disease	Indef.
Due to: Diabetes mellitus	Indef.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner, M.D. M. D. or other

Address: Baltimore - 28, Md. Date signed 4-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

04718

CERTIFICATE OF DEATH

Reg. Diat. No.....

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

.....

How long in hospitel or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residenee of mother)

State Maryland County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Stroet No. 38 Bloomingdae ave
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (a) FULL NAME Mary Gunther

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Frank Gunther

6.(c) If alive, give age.....years

7. Birth date of deceased (mo., day, yr.) June 10. 1883

8. AGE: Years	Months	Days	If less than one day
61	11	10	.....hrs. .....min.

9. Birthplace Lancaster County Virginia
(Town, county and state)

10. Usual occupation House wife

11. Industry or business

FATHER 12. Name Allen Reed

13. Birthplace Mississippi

MOTHER 14. Maiden name Harriet Taylor

15. Birthplace Lancaster County Virginia

16. Informant Frank Gunther

Address 38 Bloomingdae ave Catonsville md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24. 1945 (month) (day) (year)

Cemetery or crematory Western star Cemetery

Location Catonsville Baltimore County Md

18. Funeral director Joseph A. Sisly Funeral Home

Address 66 West Baner st Baltimore 30 md

19. 5/22 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945 at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1945, to 5/20 1945 and that I last saw h.... alive on 5/19 1945

Immediate cause of death	DURATION
Tuberculosis Pulmonary, oedema	
Due to	
Due to Carcinoma of Jr. secondary, oedema	1 yr.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? .....
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE John T Mears M. D. or other

Address 804 Cathedral St Date signed 5/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr Bacon
2810 Taylor Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

CERTIFICATE OF DEATH

T 04719

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
3023 Taylor Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3023 Taylor Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Rose M. Gutman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 1 1880

8. AGE: Years: 64 Months: Days: If less than one day: hrs. min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Pious Gutman
13. Birthplace: Germany

MOTHER
14. Maiden name: Theresa
15. Birthplace: Germany

16. Informant: Mrs Schaffer
Address: 3023 Taylor Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 1945 (month) (day) (year)
Cemetery or crematory: Parkwood
Location

18. Funeral director: L. J. Ruck
Address: 5305 Harford Rd

19. 5/14 1945 (Date rec'd by registrar) G. M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 6.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1926, to May 12 1945
and that I last saw her alive on May 11 1945

Immediate cause of death	DURATION
Gangrene, Left leg.	8 days
Due to Chronic Endocarditis,	20 yrs
mitral valve and	
Due to Hypertension	20 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statisticaDy.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: G. M. Bacon M.D.
M. D. or other
Address: 2810 Taylor Ave Date signed: 5/14/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

BC T 04720

Reg. Diat. No. 30

1. PLACE OF DEATH:

County Baltimore

City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years 11 months 14 days

Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital

How long in hospital or institution? 7 years 11 months 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1002 Madison Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war --

3.(a) FULL NAME Arthur Hammill

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 3, 1908

8. AGE: Years 37 | Months 3 | Days 2 | If less than one day ... hrs. ... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation odd jobs

11. Industry or business peddling

FATHER 12. Name Frank Hammill

FATHER 13. Birthplace Maryland

MOTHER 14. Maiden name Alice Berry

MOTHER 15. Birthplace Maryland

16. Informant Hospital records

Address Catonsville, Baltimore - 28, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5 · 9 · 45 (month) (day) (year)

Cemetery or crematory NEW CATHEDRAL

Location 3900 Old FREDERICK Rd.

18. Funeral director Harry H. Witzke

Address 4101 Edmondson Ave.

19. 5/8/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 at 4:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21, 1937, to May 5 1945 and that I last saw him alive on May 5 1945

	DURATION
Immediate cause of death: Pulmonary Oedema	4 hrs
Due to: Chronic Myocardial failure	Indef.
Due to: Hypertensive Cardio-renal disease	"
Other conditions: Pericarditis & effusion	"
Uremia	"

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other

Address Baltimore - 28, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

04721

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: U.S. Veterans Facility

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4305 Parkmont Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: Indian Insurrection

3. (a) FULL NAME: Max Robert Hanneman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married.

6.(b) Name of husband or wife: Rosalia W Hanneman

Unknown 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 29, 1859

8. AGE:

Years	Months	Days	If less than one day
86	1	16	hrs. min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: Retired Customs Insp.

11. Industry or business: U.S. Govt

FATHER 12. Name: William Hanneman

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Germany

16. Informant: Mrs M R. Hanneman

Address: 4305 Parkmont ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18th 1945 (month) (day), (year)

Cemetery or crematory: Parkwood Cemetery

Location: Baltimore, Maryland

18. Funeral director: Laegler Funeral Home

Address: 7401 Belair Road

19. May 17 1945 (Date rec'd by registrar) Mrs. G. L. Reybrden Registrar

Dawsonville Md

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945, at 7:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 15 1945, and that I last saw h. alive on May 15th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Arteriosclerosis	
General	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A M Balter Lt Col MC. M. D. or other

Address: Ft Howard Md Date signed: May 15 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

704722

Reg. Dist. No. ~~37~~ 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 years
Hospital, institution, or street address where death occurred:
York and Ridgeleigh Roads
***
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Lutherville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: York and Ridgeleigh Roads
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: FANNIE MATILDA HARMAN

3.(b) Social Security Number: ******

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Dunlop W. Harman
6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): December 9, 1896

8. AGE: Years	Months	Days	If less than one day
48	5	8	-- hrs. -- min.

9. Birthplace: Frederick Co., Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At Home
FATHER 12. Name: James Thomas White
13. Birthplace: Maryland
MOTHER 14. Maiden name: Margaret Brady
15. Birthplace: Maryland
16. Informant: Dunlop W. Harman
Address: Lutherville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22, 1945 (month) (day) (year)
Cemetery or crematory: Sater's Baptist Cemetery
Location: Lutherville, Maryland
18. Funeral director: John Burns Sons
Address: Towson, Maryland
19. May 20, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17, 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18, 1945, to May 19, 1945 and that I last saw h~~er~~ alive on 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	8 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Bennett A. Stone M. D. or other
Address: Lutherville, Md. Date signed: 5-21-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 04783 44

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Md.

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Ar. Ar.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 Chesapeake
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I ✓

3.(a) FULL NAME: JOHN WAKEFIELD HARPER, JR.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Lina Harper

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): 9-16-98

8. AGE:	Years	Months	Days	If less than one day
	46	8	4	....hrs. ....min.

8. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Diesel Engineer

11. Industry or business:

FATHER 12. Name: John W. Harper

13. Birthplace: Pennsylvania

MOTHER 14. Maiden name: Lucy Poulson

15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/23/1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff Cemetery

Location: Annapolis, Maryland

18. Funeral director: John M. Taylor

Address: Annapolis, Maryland

19. May 21 19 45 (Date rec'd by registrar) Dawson L. Harbin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1945, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945, to May 20, 1945 and that I last saw him alive on May 20, 1945

Immediate cause of death	DURATION
Generalized lympho-sarcoma	Unknown
Due to: Primary site: Unknown. Cut R.	
Due to:	
Other conditions: Suppurative broncho-pneumonia bilateral	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: A.M. Balter

A.M. BALTER, LT. COL., M.C. CLINICIAN.

Address: Ft. Howard, Md. Date signed 5-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (102)

CERTIFICATE OF DEATH

T 04724

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Balto

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
36 Portship Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Portship Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Isaac Frank Hartzell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

8.(b) Name of husband or wife: Maud Eliz. nee Teeter 8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 5 - 1885

8. AGE:

Years	Months	Days	If less than one day
60	3		hrs. min.

9. Birthplace: Cameron, W. Va.
(Town, county, and state)

10. Usual occupation: Roller

11. Industry or business: Beth. Steel

FATHER
12. Name: Frank Hartzell
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace: W. Va.

16. Informant: Maud Eliz. Hartzell
Address: 36 Portship Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/18/45 (month) (day) (year)

Cemetery or crematory: Meadowridge

Location: Wash. Blvd.

18. Funeral director: John S Connelly

Address: 418 Eastern Ave. Bmore 21

19. 5/17/45 (Date rec'd by registrar) J S Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 45, at 6 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1943 19 45, to May 15 19 45, and that I last saw him alive on May 14 19 45

Immediate cause of death: Malignant Hypertension — DURATION: 4 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A Winder, MD
M. D. or other

Address: Sparrows Pt 19 Date signed 5-16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

04725 P

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Bonnie View Nursing Home
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Kenwood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Hannah M. Healey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 3. 1863

8. AGE: Years	Months	Days	If less than one day
82	0	26	hrs. min.

9. Birthplace: England (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Benjamin Harris
13. Birthplace: England

MOTHER
14. Maiden name: Ellen Raybould
15. Birthplace: England

16. Informant: Wm. Healey
Address: 226 S. Clinton St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/31/45 (month) (day) (year)
Cemetery or crematory: Loudon Park
Location: Frederick Ave.

18. Funeral director: Clarence F. Hoffmann
Address: 1639 N. Broadway

19. 5/31 1945 (Date rec'd by registrar) Alta Hedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945 at 3.4 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 - 1945 to May 29 1945 and that I last saw h[illegible] alive on May 28 1945

Immediate cause of death	DURATION
Myocarditis	
Due to: Cerebral Hemorrhage	
Due to: Hypertension	
Other conditions: Gangrene Small toes Left	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas A Cahn M. D. or other
Address: 2145 W Ball St. Date signed: 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

04726

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 16 Sanford Ave.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Catonsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 16 Sanford Ave.
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR:

3. (a) FULL NAME: AMELIA HENTSCHEL

3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Joseph A. Hentschel
6(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): December 4, 1881
8. AGE: Years: 63 Months: 5 Days: 27 If less than one day: hrs. min.
9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: At home.
FATHER 12. Name: Peter Ehm
13. Birthplace: Germany
MOTHER 14. Maiden name: ? Vaeth
15. Birthplace: Germany
16. Informant: Joseph A. Hentschel (Husband)
Address: 16 Sanford Ave.
17. (Burial, cremation, or removal. Which?): Buried
Date thereof: 6-4-45. (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: 4430 Belair Rd. Balto., Md.
18. Funeral director: L. J. Neumann & Son
Address: 32 S. Broadway
19. (Date rec'd by registrar): 6/1/45 Registrar: H. C. Rodgers Deputy Local Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 31 19 45, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 45, to May 31 19 45, and that I last saw h alive on May 31 19 45.

	DURATION
Immediate cause of death: Chr. Myocarditis	6 mos
Due to: Carcinoma of Breast with Generalized Metastases	6 mos
Due to:	
Other conditions: Bronchial Asthma	3 mos

(Include pregnancy within 3 months of death)
Major findings: C.A. of L. Breast.
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James Hartnett M. D. or other
Address: Catonsville Date signed: 6/1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md.)

CERTIFICATE OF DEATH

Reg. Dist. No. 0172744

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Hyde Park Sta. #17

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 4205 Stanwood Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Sebastian J. Hergenroeder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Anna M. (Hisel) Hergenroeder 6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 4 - 1882

8. AGE: Years: 63 Months: 7 Days: 16 If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Supt. dye dept.

11. Industry or business: Du Pont Co.

FATHER — 12. Name: August Hergenroeder

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Mary Neudeim

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Anna M. Hergenroeder

Address: 4205 Stanwood Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23-45 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Belair Road

18. Funeral director: John J. Connelly

Address: 418 Eastern Ave. Essex

19. 5/21/45 (Date rec'd by registrar) John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20th 1945 at 12.03 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1944, to May 20 1945 and that I last saw h[illegible] alive on May 20 1945

	DURATION
Immediate cause of death: Coronary occlusion	5/19/45
Due to: Chr. Endocard. Fib	5/1944
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: William J. Hyoaer M. D. or other

Address: 801 E Kenwood Ave. Date signed: 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1572)

CERTIFICATE OF DEATH

T 04728 31

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Rusty Rock Road
City or town: Randallstown, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Randallstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rusty Rock Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Virginia Catherine Hewing

3. (b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 30, 1939

8. AGE: Years	Months	Days	If less than one day
6		23	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER
12. Name: Alvin Nones Hewing, Jr.
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Catherine Peregoy
15. Birthplace: Baltimore, Md.

16. Informant: Alvin Nones Hewing, Jr.
Address: Rusty Rock Rd. Randallstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-26-45 (month) (day) (year)
Cemetery or crematory: Lorraine Cemetery
Location: Baltimore Maryland

18. Funeral director: Henry Sander & Sons, Inc.
Address: North Ave. & Broadway

19. 5/25-45 (Date rec'd by registrar) C. W. Aldrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23, 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1944 to April 1945
and that I last saw h.. alive on April 26 1945

Immediate cause of death	DURATION
Congenital Heart Disease	
& terminal convulsion due to	
Due to: Cerebral anoxia & Pneumonia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Congenital malformation of heart.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harriet G. Guild M. D. or other
Address: Johns Hopkins Hospital Date signed: 5/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 64729 P

Reg. Dist. No. 8-38

1. PLACE OF DEATH:
County: Baltimore
City or town: Towson 4, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 mos 10 days.
Hospital, institution, or street address where death occurred:
Eudowood Sanatorium, Towson, Md.
How long in hospital or institution? 6 mos 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1752 E. Northern
(If rural, give LOCATION)
2.(a) If veteran, name war: Mexican

3.(a) FULL NAME: George Fountain Holly

3.(b) Social Security Number: 213-10-2582

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Florence Holly
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Jan 29, 1889

8. AGE: Years: 56 Months: 3 Days: 5 If less than one day: hrs. min.

9. Birthplace: Virginia Eastern Shore
(town, county, and state)

10. Usual occupation: Motorman

11. Industry or business: Balto. Transit Co

FATHER
12. Name: Benjamin Holly
13. Birthplace: Va

MOTHER
14. Maiden name: Charlotte Means
15. Birthplace: Va

16. Informant: Personal History, Hospital Records
Address: Eudowood Sanatorium, Towson, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof: May 6-1945 (month) (day) (year)
Cemetery or crematory: Woodland Memorial Park
Location: Parkville, Md.

18. Funeral director: Bryan & Bose
Address: 2234 N. Charles St.

19. 5/5 19 45 (Date rec'd by registrar) D. W. Holmes D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1945 at 3.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1944 to May 4 1945
and that I last saw h.. alive on May 3 1945
Immediate cause of death: Pulmonary TBC — DURATION: 4 yr.

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: William A. Bridges M. D. ~~or other~~
Address: Towson, 4, Maryland Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04730

Reg. Diat. No. 44

1. PLACE OF DEATH:
County: Baltimore (Eleventh)
City or town: 7326 Waldmans ave (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Jones's Creek 7326 Waldman ave (If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Elizabeth Hoppe

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: George Hoppe
6.(c) If alive, give age: 44 years
7. Birth date of deceased (mo., day, yr.): Feb. 18 - 1897

8. AGE: Years: 48 | Months: 3 | Days: 8 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Baltimore City (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home

FATHER
12. Name: John Wittenmeyer
13. Birthplace: unknown

MOTHER
14. Maiden name: Theressa Reynolds
15. Birthplace: Baltimore

16. Informant: George Hoppe
Address: 7326 Waldman ave

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 5/30/45 (month) (day) (year)
Cemetery or crematory: Oaklawn Cem.
Location: Eastern Road
18. Funeral director: Lilly and Zeiler INC.
Address: 403 S. WOLFE ST.
19. 5/29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27th 1945 at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20th 1945 to May 27th 1945 and that I last saw h.er alive on May 26th 1945

Immediate cause of death	DURATION
Carcinoma of Uterus	unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: J. H. Thomas M.D. (M. D. or other)
Address: 107 N. Main St Harwood, Md. Date signed: 5/27/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

T 04732

Reg. Dist. No. 43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Raspeburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Fullerton Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Zonia Tribby Howell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	Wh	W

6.(b) Name of husband or wife: Malcolm Howell

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 15th 1876

8. AGE: Years	Months	Days	If less than one day
68	10	11	..... hrs. ..... min.

9. Birthplace: Burton, W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At home

FATHER
12. Name: Barney Tribby
13. Birthplace: Unknown

MOTHER
14. Maiden name: Margaret Smith
15. Birthplace: Unknown

16. Informant: Earl Howell

Address: Fullerton Ave., Rappeburg RFD

17. burial (Burial, cremation, or removal. Which?) Date thereof: May 29, 1945 (month) (day) (year)

Cemetery or crematory:

Location: Martins Ferry, Ohio

18. Funeral director: Lansdale Funeral Home

Address: 7401 Belair Road

19. May 26 1945 (Date rec'd by registrar) Mo. C.L. Reginder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26th 1945, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 7th 1945, to May 26th 1945 and that I last saw her alive on May 25th 1945

Immediate cause of death	DURATION
Cardiac insufficiency	3 days
Due to: Cardiovascular disease	8 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. L. Wilkinson

A. L. Wilkinson, M. D. or other

Address: 5713 Bel Air Rd. Date signed: 5-26-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

+ 04733

Reg. Dist. No. 38

1. PLACE OF DEATH:

County Balto.

City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, institution, or street address where death occurred:
9132 Ridge Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Balto.

City or town Fullerton
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9132 Ridge Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elsie E. Howes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife B. Herbert Howes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 2/2/87

8. AGE: Years	Months	Days	If less than one day
58	3	17	..... hrs. ..... min.

9. Birthplace Balto. Md
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER
12. Name John T. Burns
13. Birthplace Balto. Md.

MOTHER
14. Maiden name Susan Arthur
15. Birthplace Harford Co. Md.

16. Informant B. Herbert Howes

Address 9132 Ridge Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/45 (month) (day) (year)

Cemetery or crematory Balto. Cem.

Location Balto. Md

18. Funeral director Lansdale Funeral Home

Address 7401 Belair Rd.

19. 5/20 19 45 (Date rec'd by registrar) G.M. Bacon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19th 1945 at 12:01 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 27 1944 to May 19 1945 and that I last saw h.. alive on May 17 1945

Immediate cause of death	DURATION
Carcinoma of ovary with metastases to	about 1 year
Due to peritoneum and liver	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma

Date of op. 8/24/44

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE G. M. Bacon M.D.
M. D. or other

Address 2810 Taylor Ave. Date signed 5/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

04734

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Baltimore
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Caroline Margaret Huber

3. (b) Social Security Number none.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	S.

6.(b) Name of husband or wife —
6.(c) If alive, give age ysars

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1868

8. AGE: Ysars	Months	Days	If less than one day: hrs.	min.
77	5	1		

9. Birthplace Mc Donogh, Balto. Md. (Town, county, and state)
10. Usual occupation House Keeper
11. Industry or business —

FATHER
12. Name Charles Huber
13. Birthplace Hanover, Pa.

MOTHER
14. Maiden name Elizabeth Davis
15. Birthplace dont Know

16. Informant Mrs. Helen Woolford
Address Owings Mills

17. Burial (Burial, cremation, or removal? Which?) Date thereof May 9, 1945 (month) (day) (year)
Cemetery or crematory Pleasant Hill
Location Owings Mills

18. Funeral director Wm. Berryman & Sons
Address Reisterstown, Md.

19. May 7 1945 (Date rec'd by registrar) Mary B. Eline. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6th 1945 at 12:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1941 to May 6th 1945 and that I last saw h.w. alive on May 5th 1945

Immediate cause of death — DURATION

Chronic Myocarditis — 2 yrs.
Due to Coronary Sclerosis — 2 yrs.
Due to Art Sclerosis — 5 yrs.
Other conditions Hypertension — 5 yrs.
(Include pregnancy within 3 months of death)

Major findings of operation —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE James A. Miller M.D. M. D. or other
Address Pikesville-8, Md. Date signed 5/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

BC P

04735

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 Days
Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland
How long in hospital or institution? 38 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1821 Ensor St.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: CARLOS ORMAN JACKMAN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Alice Jackman
6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): 10-15-96

8. AGE: Years	Months	Days	If less than one day
48	6	23	...hrs. ...min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Zimmion Jackman
13. Birthplace: Ohio

MOTHER
14. Maiden name: Anna Thomas
15. Birthplace: Ohio

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 5-12-45 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Greenmount Ave.

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 5/11/45 (Date rec'd by registrar) A. W. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945 at 5:00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 1945 to May 9, 1945 and that I last saw him alive on May 9, 1945

Immediate cause of death	DURATION
Broncho-Pneumonia	6 weeks plus
Due to:	
Due to:	
Other conditions: Disease of heart, cardiac enlargement, myocardial damage, and insufficiency, class IV. Arthritis, chr. Vitiligo	1 Yr. plus

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: Broncho-Pneumonia
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work? No

23. SIGNATURE: A.M.Balter
A.M.BALTER, LT.COL., M.C. CLINICAL DIR.
Address: Fort Howard, Maryland Date signed: 5-9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

04736

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Baltimore

City or town Sparrows Point

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3rd + C St.

How long in hospital or institution? 39 yrs at B.L.Co.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Baltimore.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1511 Jefferson St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Peter Jackson.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Married.

6.(b) Name of husband or wife Sadie Jackson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 4, 1884

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace Berkville, Va.

(Town, county, and state)

10. Usual occupation Trackman

11. Industry or business ~~Bethlehem~~ Steel Co. & B.R.R.R.

FATHER

12. Name Jordon Jackson

13. Birthplace Va

MOTHER

14. Maiden name Susan Jackson

15. Birthplace Va

16. Informant Hospital Sparrows Point

Address Sparrows Point Md.

17. Burial Date thereof May 25, 1945

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hughsville

Location Berkville Va

18. Funeral director Elroy O. Wilson

Address 1000 Brantley ave

19. 5/25 1945 A. W. Bedrick

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 24 1945 at 5 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1945 to May 24 1945

and that I last saw h...tive on 19

Immediate cause of death	DURATION
Coronary occlusion	Hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. McCormick M.D.

M. D. or other

Address Dundalk, Md. Date signed 5/25/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04737

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
2200 Old Orems Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Middle River
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2200 Old Orems Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Duvall Jenkins

3.(b) Social Security Number: ***

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Joseph H. Jenkins
6.(c) If alive, give age: years

7. Birth data of deceased (mo., day, yr.): August 7th, 1869

8. AGE: Years	Months	Days	If less than one day
75	9	9	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Richard H. Duvall
13. Birthplace: Maryland

MOTHER
14. Maiden name: Laura Hancock
15. Birthplace: Maryland

16. Informant: Mrs. Charles Neeld
Address: 2111 Orems Road

17. burial (Burial, cremation, or removal. Which?) Data thereof: May 19, 1945 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Balto., Md.

18. Funeral director: Lassahn Funeral Home
Address: 7401 Belair Road

19. 5/17/45 (Date rec'd by registrar) John H. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16th, 1945 at 6:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1943 to May 16 1945
and that I last saw h... alive on May 15 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John C. Baier M.D.
M. D. or other
Address: 815 Eastern Ave. Date signed: May 17/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

04738

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, Institution, or street address where death occured: 3302 Wilroughby Ave
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Parkville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3302 Wilroughby Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Holger H. Jochumsen

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Anna N. Wuland
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 5, 1897

8. AGE: Years	Months	Days	If less than one day
47	4	28	..... hrs. ..... min.

9. Birthplace: Denmark (Town, county, and state)
10. Usual occupation: Machinist
11. Industry or business: Standard Sanitary Co.

FATHER
12. Name: Lawrence Jochumsen
13. Birthplace: Denmark

MOTHER
14. Maiden name: unknown
15. Birthplace: Denmark

16. Informant: Mrs. Anna Jochumsen
Address: 3302 Wilroughby Ave.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 5. 5. 45 (month) (day) (year)
Cemetery or crematory: London Park
Location: 3801 Frederick Ave.

18. Funeral director: Harry H. Wirfs
Address: 4101 Edmondson Ave.

19. 5/5 1945 C. W. Hedrich Registrar
(Date rec'd by registrar)
per H D

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5. 3 1945, at 2 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1944, to May 3 1945
and that I last saw h... alive on May 3 1945

Immediate cause of death	DURATION
Hypostatic Pneumon.	5/1/45
Due to Carcinoma of Pancreas	8/1/44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William J. Rysaner M. D. or other
Address: 801 E Kenwood Ave Date signed: 5/8/45

M

I

1

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 102

CERTIFICATE OF DEATH

04739

Reg. Dist. No. 44

1. PLACE OF DEATH:

County Balto

City or town Stemmers Run

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:

Golden Ring Rd

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto

City or town Stemmers Run

(If outside city or town limits, write RURAL and give nearest town)

Street No. Golden Ring Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alice S Johnson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife J. F. Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 2nd 1881

8. AGE: Years	Months	Days	If less than one day
63	10	13	..... hrs. ..... min.

9. Birthplace Pendleton, S.C.

(Town, county, and state)

10. Usual occupation at home

11. Industry or business

FATHER 12. Name Amos Davenport

13. Birthplace Ind.

MOTHER 14. Maiden name Mary McCluskey

15. Birthplace Ind.

16. Informant J. F. Johnson

Address Stemmers Run Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 (month) 27 (day) 45 (year)

Cemetery or crematory Miami Fla.

Location Miami Fla.

18. Funeral director Lasalle Funeral Home

Address 7401 Belair Rd

19. May 23 1945 (Date rec'd by registrar) John B. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22, 1945, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 15 1945 to May 22 1945

and that I last saw her alive on May 18th 1945

Immediate cause of death	DURATION
Heart Failure	
Due to Hypertension	4 years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Gutman M.D.

M. D. or other

Address 901 Fuselage Ave Date signed 5/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 30

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
(a) Baltimore ~~City~~ Co. Maryland Catonsville
(b) Street address 20 Lincoln Avenue
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Baltimore
(c) City or town Catonsville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 20 Lincoln Avenue
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Hilda Johnson

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Female	Negro	Married

6 (b) Name of husband or ~~wife~~ Leon

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 5, 1902

8. AGE: Years	Months	Days	If less than one day
42	10	26	hr. min.

9. Birthplace Baltimore, Maryland
(Town, county, and state)

10. Usual Occupation none

11. Industry or business none

FATHER
12. Name John Daw
13. Birthplace Virginia

MOTHER
14. Maiden Name Clara Daw
15. Birthplace Virginia

16 (a) Informant Leon Johnson
(b) Address 20 Lincoln Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof June 4, 1945 (month) (day) (year)
(c) Cemetery or crematory New Cathedral
Location Baltimore, Maryland

18 (a) Funeral director Charles L. Law
(b) Address 892-24 Fredrick Ave.

19 (a) 6/4/45 (Date received by registrar) (b) H. O. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945, at 4 ~~A~~ P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 3 1945 to 5/31 1945, and that I last saw h~~er~~ alive on 5/31 1945.

Immediate cause of death Cardiac Hypertrophy — Duration

Due to — Duration

Due to — Duration

Other Conditions — Duration

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)
(e) Means of injury

23. Signature B. J. Hatcher M. D.

Address 1 W. Ks Parkway Date signed 6/2/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (737)

CERTIFICATE OF DEATH

04741 P

Reg. Dist. No. .....

VS A15 (T) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. (I) MARGIN RESERVED FOR BINDING (M)

1. PLACE OF DEATH:
County Baltimore County
City or town Bradshaw
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Baltimore
City or town Bradshaw
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Jeanette Dutton Johnson

3. (b) Social Security Number .....

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	col.	Married

6.(b) Name of husband or wife John Mayor Johnson
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) 4 March 1898

8. AGE:

Years	Months	Days	If less than one day
67	2	11	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Charles Brown
13. Birthplace Md.

MOTHER
14. Maiden name Caroline Dorsey
15. Birthplace Md.

16. Informant John Johnson
Address Bradshaw Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1945 (month) (day) (year)
Cemetery or crematory Asbury Cemetery
Location Lonely Md.

18. Funeral director Mrs Robert A. Elliott & Son
Address 1129 N. Caroline St.

19. 5/7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 15 May 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1944, to 15 May 1945
and that I last saw her alive on 15 May 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Hypertensive Cardio Vascular Disease	11 yrs
Due to:	
Other conditions: nodular Goitre	40 yrs

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Clifford F. Hudson, M.D.
M. D. or other
Address York, Md. Date signed 5/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

04742

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Texas

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 38 yrs 8 da.

Hospital, Institution, or street address where death occurred:

Balto. Co., Home

How long in hospital or institution? 38 yrs. 8 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Tillie Jones

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widowed

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): about 1865

8. AGE: Years: about 80 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland. (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER — 12. Name: William Curtis

13. Birthplace: Md.

MOTHER — 14. Maiden name: Sarah Ellen Roberts

15. Birthplace: Md.

16. Informant: Balto. Co., Home Register

Address: Texas, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23 1945 (month) (day) (year)

Cemetery or crematory: Balto. Co. Home Cemetery

Location: Texas, Md.

18. Funeral director: Lyndon Brooks

Address: Sparks, Md.

19. May 22 1945 (Date rec'd by registrar) Wm. J. Schnitzer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945 at 4 45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct - 15 1940, to May 22 1945 and that I last saw h. alive on 5/20 1945

	DURATION
Immediate cause of death: Carcinoma — (Breast.)	5 yrs.
Due to:	
Due to:	
Other conditions: Endocarditis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Holmes C. Ewart M.D. M. D. or other

Address: Cockeysville Md. Date signed 5/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04743

Reg. Dist. No. 41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Rural Rt. Dundalk

(If outside city or town limits write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 7321 Manchester Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Robert Kastner

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Katherine

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30. 1878

8. AGE: Years: 67 | Months: 1 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: W. Va. (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: Am. Smelting Refining Co

FATHER — 12. Name: Robert E. Kastner

13. Birthplace: Germany

MOTHER — 14. Maiden name: Elisa Von Wreskole

15. Birthplace: Germany

16. Informant: Mrs. Katherine Kastner

Address: 7321 Manchester Rd

17. (Burial, cremation, or removal, Which?): Burial Date thereof: 5/18/45 (month) (day) (year)

Cemetery or crematory: Oak Lawn

Location: Baltimore Co. Md.

18. Funeral director: Wilson Earl Lee

Address: 1214 S. Broadway

19. 5/17/45 (Date rec'd by registrar) D. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1945, at 10:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10th 1945, to May 15 1945 and that I last saw him alive on May 15 1945

	DURATION
Immediate cause of death: Cardio-vascular Renal	days
Due to:	
Due to:	
Other conditions: Arterial Hemorrhage	5 days.

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.:

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: James H. White M.D. M. D. or other

Address: 7601 Eastern Ave. Baltimore 24 Md. Date signed: 5/16/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

04744

1. PLACE OF DEATH

County Baltimore, County — Registration Dist. No.

Village or City Pikesville — No. 6404 Liberty Road St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ... yrs. ... mos. 30 ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

2. FULL NAME Auguasta L. Katz

(a) Residence: No. 337 New Castle Rd St., Ward. Rochester, N. Y.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6. DATE OF BIRTH (month, day, and year) Feb. 15, 1871

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
74	3	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Georgia (State or country)

FATHER

13. NAME Isacc Landuer

14. BIRTHPLACE (city or town) Germany (State or country)

MOTHER

15. MAIDEN NAME Rosalie Leopold

16. BIRTHPLACE (city or town) Georgia (State or country)

17. INFORMANT Mr. Richard J. Katz

(Address) 337 New Castle Rd. Rochester

18. BURIAL, ~~CREMATION~~, OR ~~REMOVAL~~ MT Hope N.Y.

Place Rochester, N.Y. Date 5/14/45, 19...

19. UNDERTAKER David Dondheim & Son

(Address) 1902 Eutaw Place, Baltimore-17

20. FILED 5/12, 19 45 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 11th (Month) (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from April 21st, 1945, to May 11th, 1945

I last saw her alive on May 10, 1945; death is said to have occurred on the date stated above, at ... m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Respiratory & cardiac failure	10 days
Other **Contributory Causes** of Importance:	
Arteriosclerosis	3 yrs

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy? ...

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) I. Frederick Lentz M. D.

(Address) Temple Garden Apt.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-4)

CERTIFICATE OF DEATH

04745

Reg. Dist. No.

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH

County: Balto. Co.

City or town: Sparrow Point Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Balto

City or town: Sparrow Point

(If outside city or town limits, write RURAL and give nearest town)

Street No. 632 E. 7th St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margaret Kelly.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 15-1922

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
22	6	6		

9. Birthplace: Phila. Pa. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Joseph J. Kelly

FATHER — 13. Birthplace: Balto. Md.

MOTHER — 14. Maiden name: Mary Eberle

MOTHER — 15. Birthplace: Pa.

16. Informant: Helen C. Kelly

Address: 632 E. 7th St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 24 1945 (month) (day) (year)

Cemetery or crematory: New Cath.

Location: Old Frederick Rd.

18. Funeral director: John J. Milan

Address: 3000 E. Balto. St.

19. May 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21-45 19..... at 10 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 19 45 to May 21 19 45

and that I last saw h... alive on May 19 19 45

Immediate cause of death	DURATION
Cerebral Embolism	
Due to: Chronic Rheumatism	
Carditis	
Due to	
Other conditions Acute Pyelitis	

(Include pregnency within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. Windsor M.D. M. D. or other

Address: Sparrows Pt. Md. Date signed 5-22-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

Street No. 31 Kelvin Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth King

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 8, 1857

8. AGE:

Years	Months	Days	If less than one day
87	9	4	..... hrs. ..... min.

8. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: At Home

11. Industry or business

FATHER
12. Name: Major P. H. King U. S. A.
13. Birthplace: Frederick, Md.

MOTHER
14. Maiden name: Mary Elizabeth Heuisler
15. Birthplace: Baltimore

16. Informant: Mrs. Albert Sehlstedt
Address: 31 Melvin Ave. Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)

Cemetery or crematory: St. Ignatius Cemetery

Location: Hickory, Harford Co., Md.

18. Funeral director: H. W. Meuse & Son

Address: 805 North Calvert street

19. 5/13 1945 H. C. Aldridge Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1945, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1944, to May 12 1945 and that I last saw h~~e~~ alive on May 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Left Hemiplegia	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Howard W. Sweeney M. D. or other

Address: Catonsville, Md. Date signed: 5/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC P

04747 Y4

Reg. Diat. No.

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 10 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1435 Henry Street
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: JOHN KIRBY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Iva Kirby

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): 11-24-94

8. AGE:	Years	Months	Days	If less than one day
	50	5	25	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business:

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: Emma Kirby
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23-1945 (month) (day) (year)
Cemetery or crematory: Park Loudon Cemetery
Location: Baltimore, Md.

18. Funeral director: A. Howard Evans
Address: 1400 S. Charles St., Balto., Md.

19. 5/21/45 (Date rec'd by registrar) A W Heldmd D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1945, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1945, to May 20, 1945 and that I last saw him alive on May 20, 1945

Immediate cause of death	DURATION
Nephritis, chr., with edema	1 Yr. plus
Due to:	
Due to:	

Other conditions: Disease of the Heart: Cause: Nephritis Structural Lesions: Myocardial Damage; Myocardial Enlargement; Pericarditis Manifestations: Myocardial Insufficiency;

Major findings of operation: Lead poisoning, chr. Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert M. Cullison
R.M. CULLISON, MAJOR, M.C. D. or other

Address: FORT HOWARD, MD. Date signed: 5-20-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (442)

04748 4 2

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Baltimore, Md
City or town Relay (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Relay (If outside city or town limits, write RURAL and give nearest town)
Street No. 1721 Arlington Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Carl Edward Knellinger
3. (b) Social Security Number

4. Sex M
5. Color or race W.
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Frances V.
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept 15, 1856
8. AGE: Years 88 Months 8 Days 3 If less than one day ... hrs. ... min.
9. Birthplace Harford County Md (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Retired
FATHER 12. Name George Knellinger
13. Birthplace Germany
MOTHER 14. Maiden name Elizabeth Bush
15. Birthplace Harford County Md
16. Informant Mrs Charles [illegible]
Address 1721 Arlington Ave Relay Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1945 (month) (day) (year)
Cemetery or crematory Jerusalem Christian (Jeffa)
Location Harford County
18. Funeral director Wm [illegible] Inc
Address Baltimore Md
19. 5/19 1945 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945, at 4:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945, to May 18 1945
and that I last saw him alive on May 17 1945

	DURATION
Immediate cause of death Carcinoma of stomach c̄	6 mo
Due to General carcinomatosis	
Due to Ch. Myocarditis	2 mo
Generalized arteriosclerosis	
Other conditions Senility	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Elkridge, Md Date signed 5/18/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlee St., Baltimore

CERTIFICATE OF DEATH

04749

Reg. Diat. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22yrs 11mo 14da
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? 22yrs 11mo 14da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Krakower, Gershom

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): October 8, 1906

8. AGE: Years	Months	Days	If less than one day
38	7	6	____ hrs. ____ min.

9. Birthplace: Baltimore, Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Inmate
11. Industry or business

FATHER
12. Name: Abraham Krakower
13. Birthplace: Russia

MOTHER
14. Maiden name: Rebecca Crook
15. Birthplace: Russia

16. Informant: David Krakower
Address: 4037 Fairfax Rd., Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/15/45 (month) (day) (year)
Cemetery or crematory: United Hebrew
Location: Washington Blvd
18. Funeral director: Sol Levinson Bros
Address: 1124 W Pratt ave
19. 5-14-45 (Date rec'd by registrar) E.E. Nichols Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 19 45 at 9:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 19 45 to May 14 19 45 and that I last saw h...im...alive on May 14 19 45

Immediate cause of death	DURATION
Cardiac insufficiency	1yr 9mo
Due to	
Due to	
Other conditions: Pulmonary tuberculosis (arrested)	9yr11mo

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H.S. Cutler M. D. or other
Address: Rosewood Owings Mills, Md. Date signed 5/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04750

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Baltimore Co.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs.
Hospital, institution, or street address where death occurred: None
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MD County: Baltimore
City or town: Balto.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1013 Keeds Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Margaret B. Krug

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Krug ✓
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 2 - 1860

8. AGE: Years	Months	Days	If less than one day
84	7	9	..... hrs. ..... min.

8. Birthplace: Baltimore, MD. (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: Home
FATHER 12. Name: Daniel Hammerbacker
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Menger
15. Birthplace: Germany
18. Informant: Mrs. Halver B. Kaufman
Address: 1013 Keeds Avenue
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-14-45 (month) (day) (year)
Cemetery or crematory: Western Cemetery
Location: Edmondson Avenue
18. Funeral director: C. Raymond Kaufman
Address: 1026 Keeds Avenue.
19. May 12 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 19 45 at 3:40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 26 1945 to May 11 1945
and that I last saw ..... alive on May 11 1945

Immediate cause of death	DURATION
Acute myocarditis	
Due to General debility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Thos. H. Ridenour M. D. or other
Address: 1939 Edmondson Ave. Date signed: May 12 45

04751

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 Hrs.

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Ft. Howard, Md.

How long in hospital or institution? 11 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2314 Druid Park Drive
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: ISADORE LAZARUS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Rose Lazarus

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 15, 1888

8. AGE: Years	Months	Days	If less than one day
56	10	5	..... hrs. ..... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business:

FATHER — 12. Name: ? U. K.

13. Birthplace: ? Russia

MOTHER — 14. Maiden name: ? U. K.

15. Birthplace: Russia

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Ft. Howard, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22/45 (month) (day) (year)

Cemetery or crematory: Hebrew Young Men's Cemetery

Location: Windsor Mill rd., Maryland

16. Funeral director: Sol. Levinson & Bros.

Address: 1126 W. North Ave., Balto., Md.

19. 5/22 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1945 at 6:00 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20, 1945, to May 21, 1945 and that I last saw him alive on May 21, 1945

Immediate cause of death	DURATION
Cardiac Disease, Cause Unknown	2 Yrs.
Due to: Myocardial Insufficiency, Pulmonary Edema	
Due to:	
Due to:	
Other conditions: Pyelonephritis, chr.	
Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Rme, A.M. Balter
A.M. BALTER, LT.COL., M.C. MCLIN Notified HR.

Address: Ft. Howard, Md. Date signed: 5-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 04752

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Catonsville, Md

(c) Hospital or institution: 5501 Edmondson Ave. Hood Nursing Home

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County

(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)

(d) Street No. 526 N. Fulton Ave. (If rural give location)

(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME EMMA GRACE LEBER

3 (b) If veteran, name war: None

3 (c) Social Security Account No.: None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: --

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 5, 1870

8. AGE: Years 74 | Months 8 | Days 24 | If less than one day hr. min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual Occupation None

11. Industry or business

FATHER

12. Name Jacob H. Leber

13. Birthplace York, Pa.

MOTHER

14. Maiden Name Emma Tilyard

15. Birthplace Balto., Md.

16 (a) Informant Mrs. J. Wm. Kempel

(b) Address 4017 Liberty Heights Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/31/45 (month) (day) (year)

(c) Cemetery or crematory Lorraine Cem.

Location Balto., Md.

18 (a) Funeral director WM. J. TICKNER & SONS

(b) Address Balto., Md.

19 (a) (Date received by registrar) (b) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29, 1945, at 4:15 AM

21. I certify that death occurred on the date above stated; that I attended deceased from Nov 1942 to May 29 1945, and that I last saw her alive on May 19 1945

Immediate cause of death: Carcinoma left breast — Duration: 3 years

Due to:

Due to:

Other Conditions: Auricular fibrillation (Include pregnancy within 3 months of death)

Date of operation:

Major findings of operation:

of autopsy:

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? While at work? (Specify type of place)

(e) Means of injury

23. Signature H. M. Collins

Address 3321 Fredrick Date signed 5/29/45 M.D.

VS 150

5/31/45

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73rd

CERTIFICATE OF DEATH

04753

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Hollofield, Balto. Co.
City or town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Raymond Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Daniels, Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: World War #1 ✓

3. (a) FULL NAME: George Edward Lewis

3. (b) Social Security Number: 245-09-8327

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah Lewis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar. 9, 1896

8. AGE: Years	Months	Days	If less than one day
49	2	11	hrs. min.

9. Birthplace: Greensborough N.C. (Town, county, and state)
10. Usual occupation: Oiler in spinning room
11. Industry or business: C.K. Daniels Mill
FATHER 12. Name: Charles C. Lewis
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Johanna Driscoms
15. Birthplace: N. Carolina
16. Informant: Mrs. Sarah Lewis
Address: Daniels, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/22/45 (month) (day) (year)
Cemetery or crematory: Shipped to Greensboro N.C.
Location:
18. Funeral director: Easton Sons
Address: Ellicott City Md.
19. 5/22/45 (Date rec'd by registrar) [signature] Registrar
County Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 1945, at 11:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Cardio Vascular	
Due to: Uraemia	
Other conditions: Injuries	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. M. Kieffer M.D. Capt. Med. Res. U.S. Army
M. D. or other
Address: 1010 Leede Date signed: 5-21-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

04754 P

Reg. Dist. No. 32

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: AUGSBURG HOME
County BALTIMORE
City or town PIKESVILLE MD
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County BALTO.
City or town PIKESVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. CAMPFIELD ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MARTHA. LINS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEM.	WHITE	SINGLE

6.(b) Name of husband or wife —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) MAY. 26. - 1861

8. AGE: Years	Months	Days	If less than one day
83	11	21	hrs. min.

9. Birthplace (Town, county, and state)
10. Usual occupation NONE.
11. Industry or business
FATHER 12. Name JACOB LINS
13. Birthplace GERMANY.
MOTHER 14. Maiden name LOUISA.
15. Birthplace GERMANY
16. Informant AUGSBURG. HOME RECORDS
Address CAMPFIELD RD. PIKESVILLE MD
17. BURIAL Date thereof 5. 19-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory WESTERN. CEMETERY.
Location BALTIMORE MD
18. Funeral director Mrs Chas A. G. ROHDE
Address 2327 Edmondson Ave
19. 5/18 19 45 D.W Reduel D.M.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY. 17 19 45, at 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 5th 19 45 to May 17 19 45
and that I last saw h.. alive on - May 12 - 19 45

Immediate cause of death
1) Arterio Sclerotic
Heart Disease

DURATION: 5 yrs.

Due to

Due to

Other conditions - Acute Infectious Arthritis

DURATION: - 6 weeks

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Earl L. Chambers
M. D. or other
Address 4108. Liberty Hts. Date signed 5/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04755

Reg. Dist. No. 37

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs

Hospital, Institution, or street address where death occurred: Masonic Home Cockeysville

How long in hospital or institution? 9 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: Essex Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lutz Ave

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Melissa L. Madison

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frank A. Madison

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 17, 1870

8. AGE: Years	Months	Days	If less than one day
74	6	22	hrs. min.

9. Birthplace: Worthington Pa (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Solomon Hunsex

FATHER — 13. Birthplace: Armstrong County Pa

MOTHER — 14. Maiden name: Elsie Jane Wattson

MOTHER — 15. Birthplace: Armstrong County, Pa

16. Informant: Laura M. Schneider

Address: Masonic Home, Cockeysville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11 - 45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Baltimore

18. Funeral director: Geo. L. Berger Jr.

Address: 1512 Hollins St

19. May 10 45 (Date rec'd by registrar) — L.M. Schneider Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 1945, at 12:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1936 to May 9 1945 and that I last saw her alive on May 9 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	week
Due to: Carcinoma of Stomach	1 yr.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wallace F. Skeldman M.D. M. D. or other

Address: 6 E. Biddle St Date signed: 5/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

04756 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Baltimore

City or town Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Veterans Administration Facility

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3723 Keswick Road
(If rural, give LOCATION)

2.(a) If veteran, name war World War

3.(a) FULL NAME
FRANK MAGGIO

3.(b) Social Security Number
Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Marian Maggio

6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) Dec. 18, 1893

8. AGE:	Years	Months	Days	If less than one day
	51	4	14	.....hrs. .....min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business

FATHER
12. Name Philip Maggio
13. Birthplace Italy

MOTHER
14. Maiden name Catherine Guerico
15. Birthplace Italy

16. Informant Clinical Records, Veterans Administration, Fort Howard, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1945 (month) (day) (year)

Cemetery or crematory New Cathedral Cemetery

Location Baltimore, Md.

16. Funeral director Pipitone Funeral Home

Address 2818 E. Balto. St. Balto. Md.

19. 5/4 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1945 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30 1945 to May 2 1945 and that I last saw him alive on May 2 1945

Immediate cause of death	DURATION
Coronary occlusion, acute	
Due to Coronary heart disease	4 yrs. plus
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. M. BALTER, LT. COL., CLIN. DIRECTOR

Address Fort Howard, Md. Date signed 5/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

T

04757

Reg. Dist. No. 30

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 133 Oakdale Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John J Mahle

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Marie L
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): July 4 1867

8. AGE: Years 77 | Months 10 | Days 2 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Not Available
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Mrs. Earl Mahle
Address: 130 Oakdale Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-9-45 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Baltimore Md.

18. Funeral director: Everett Pauley
Address: Catonsville Md.

19. 5-8 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6, 19 45 at 4:30 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 1945, to May 6 1945
and that I last saw h alive on May 6 1945

	DURATION
Immediate cause of death: Myocardial Decompensation	2wks.
Due to: Hypertensive Cardio-vascular disease	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wilmer L. Gallagher M.D.
M. D. or other
Address: Catonsville 28, Md. Date signed: 5-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04758 P

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Timonium
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
30 Northwood Drive
How long in hospital or institution? 4 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Timonium
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 30 Northwood Drive
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: PAULINE EMILY MANZKE

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Ernest H. Manzke
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan. 13, 1895

8. AGE: Years	Months	Days	If less than one day
50	4	12	hrs. min.

9. Birthplace: Pa. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: Franklin S. Wagner
FATHER 13. Birthplace: Pa.
MOTHER 14. Maiden name: Martha Scoll
MOTHER 15. Birthplace: Pa.
16. Informant: Mr. Ernest H. Manzke
Address: 30 Northwood Drive, Timonium
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/28/45 (month) (day) (year)
Cemetery or crematory: Parkwood Cem.
Location: Balto., Md.
18. Funeral director: WILLIAM J. TICKNER & SONS
Address: Balto., Md.
19. 5/26/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25, 19 45 at 5:00 a. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 30, to May 25 19 45
and that I last saw h[er] alive on May 11 19 45
Immediate cause of death: Cardio-Vascular Disease — DURATION: 15 yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fritz J. Kunzog M D
M. D. or other
Address: 2700 HARFORD Rd. Date signed: 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04759 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville, Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Several years
Hospital, Institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 23 Wesley Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ella Matthews

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	c	married

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 1897

8. AGE: Years	Months	Days	If less than one day
47			...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business —

FATHER
12. Name Chas E. Matthews
13. Birthplace Maryland

MOTHER
14. Maiden name Ella Parron
15. Birthplace Maryland

16. Informant Mrs. Mildred Petrone
Address 23 Wesley Ave. Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/17/45 (month) (day) (year)
Cemetery or crematory Western Star
Location

18. Funeral director Adolphus Halstead
Address 918 Edmondson Ave

19. 5/17 (Date rec'd by registrar) 1945 A. Z. Hedrick M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945 at 2 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-21-45 19... to 5-13-45 19...
and that I last saw h... alive on 5-13-45 19...

Immediate cause of death	DURATION
Acute Myocarditis	23 days
Due to —	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. F. Maloney M. D. or other
Address Catonsville, Md Date signed 5/14/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

T 04760

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Relay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Relay Sanitarium
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL, and give nearest town)
Street No. 109 Rosewood Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ida Pearl McAfee

3.(b) Social Security Number: 217-09-7190

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Carroll McAfee
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 25, 1883

8. AGE: Years	Months	Days	If less than one day
61	6	27	..... hrs. ..... min.

9. Birthplace: Howard Co. (Town, county, and state)
10. Usual occupation: Secretary
11. Industry or business: Stein Bros & Boyce

FATHER
12. Name: Augustus Selby
13. Birthplace: Howard Co., Md.

MOTHER
14. Maiden name: Mary Ridgely
15. Birthplace: Howard Co. Md.

16. Informant: Mrs. Nancy Selby
Address: 109 Rosewood Ave Catonsville

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 24 1945 (month) (day) (year)
Cemetery or crematory: Mt. View Cem.
Location: Shaks Corner
18. Funeral director: Easton Sons
Address: 608 Frederick Av. Catonsville

19. 5/24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945, at 1:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 17 1945, to May 22 1945 and that I last saw h.. alive on May 22 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days.
Due to: Hypertension Cardio Vas. Cular Disease	3 yrs
Due to:	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jane Stevens M. D. or other
Address: Catonsville Date signed 5/23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

04461

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82a)

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County: Balto.

City or town: Overlea
(If outside city or town limits, write RURAL and give nearest towo)

How long in above place of death?

Hospital, institution, or street address where death occurred:
115 Belmar Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give resideoce of mother)

State: Md. County: Balto.

City or town: Overlea
(If outside city or town limits, write RURAL aod give oearest town)

Street No. 115 Belmar Ave.
(If rural, give LOCATION)

2.(a) If veleran, name war

3. (a) FULL NAME: Andrew J. Mc Donald

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

8.(b) Name of husband or wife: Anna M. McDonald

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 22, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	13	..... hrs. ..... min.

9. Birthplace: Balto., Md.
(Town, county, and state)

10. Usual occupation: Retired Iron Moulder

11. Industry or business: B. & O. R. R.

FATHER
12. Name: Andred J. McDonald
13. Birthplace: Ireland

MOTHER
14. Maiden name: Anna M. McDonald
15. Birthplace: Ireland

16. Informant: Mrs. Marie A Leifert
Address: 115 Belmar Rde.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/9/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 5-7-45 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 45, at 1-20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 23 - 19 45, to May 5 19 45

and that I last saw h... alive on May 5 19 45

Immediate cause of death: Cerebral Hemorrhage (15 days) — DURATION

Due to: Hypertension

Due to: Contusion

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 5201 Belair Rd. Date signed 5-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (25)

CERTIFICATE OF DEATH

Reg. Dist. No. 0476 30

1. PLACE OF DEATH:
County Balto.
City or town Catonsville
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital or institution 16 Dusting Ave
Stay in hospital or inst. (yrs., or mos., or days) 7 mos
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Mary Ellen Moore

3. (b) Social Security Number

4. Sex F

5. Color or race W

6.(a) Single, married, widowed, or divorced Single

8 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 13 1875

8. AGE: Years 69 | Months 11 | Days 25 | If less than one day ___ hrs. ___ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Thomas H Moore

13. Birthplace Delaware

MOTHER 14. Maiden name Virginia Jones

15. Birthplace Delaware

16. Informant Mrs Joseph A Graham
Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-9-45 (month) (day) (year)

Cemetery or crematory Parsons Cemetery

Location Salisbury Md

18. Funeral director Engle & Tabby

Address Catonsville Md

19. 5/5 (Date rec'd by registrar) 1945 [signature] Registrar
Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7 1945, at 8 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 8 1945, to May 7 1945, and that I last saw h[illegible] alive on May 6 1945.

	DURATION
Immediate cause of death: Congestive Heart Failure	1 wk.
Due to: Generalized arteriosclerosis and hypertension cardio-renal disease	7.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wilbur K. Gallagher M.D.
M. D. or other

Address Catonsville-28, Md. Date signed 5/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

04763

CERTIFICATE OF DEATH

Reg. Diat. No. 87

1. PLACE OF DEATH:

County: Baltimore

City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61 Years

Hospital, Institution, or street address where death occurred: Wight Avenue

How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Cockeysville
(If outside city or town limits, write RURAL and give nearest town)

Street No. Wight Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3.(a) FULL NAME: John Merryman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sally Love

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): April 22, 1884

8. AGE: Years	Months	Days	If less than one day
61	0	21	---hrs. --min.

9. Birthplace: Cockeysville, Md.
(Town, county, and state)

10. Usual occupation: Steamship Business

11. Industry or business: Roosevelt Steamship Co.

FATHER
12. Name: Nicholas Bosley Merryman
13. Birthplace: Cockeysville, Md.

MOTHER
14. Maiden name: Willie McCleskey
15. Birthplace: Georgia

16. Informant: Nicholas B. Merryman
Address: Cockeysville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/16/45 (month) (day) (year)

Cemetery or crematory: Sherwood P. E.

Location: Cockeysville, Md.

18. Funeral director: H. W. Mears and Son

Address: 805 N. Calvert Street

19. 5/14/45 (Date rec'd by registrar) O. M. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1945, at 11.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 17 1945 to May 12 1945 and that I last saw him alive on May 12 1945

Immediate cause of death	DURATION
Cardiac Decompensation	10 Wks.
Due to Cardiac Infarct.	10 Wks.
Due to Coronary Thrombosis	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Bennett A. Stacey M. D. or other

Address: Lutherville, Md. Date signed: 5-14-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 87a

CERTIFICATE OF DEATH

T 04764

Reg. Dist. No. 37

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1945 - 78

1. PLACE OF DEATH:

Couoty Baltimore

City or town Suitland (Rural)
(If outside city or town limits, writn RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street sddress where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants givn residence of mother)

State Maryland County Baltimore

City or town Suitland (Rural)
(If outsidn city or town limits, write RURAL and give nearest town)

Street No. Branchway Rd.
(If rural, givo LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Mary C. Miedwig (MIEDWIG) **3. (b) Social Security Number** —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife John E. Miedwig

6.(c) If alive, give age 75 years

7. Birth dats of deceased (mo., day, yr.) Feb. 19, 1870

8. AGE: Years	Months	Days	If less than one day
75	2	21	hrs. min.

9. Birthpisce York Co., Penn.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Shambaugh

13. Birthplace Germany.

MOTHER 14. Maiden name Anna Miller

15. Birthplace Germany.

16. Informant John E. Miedwig

Address Suitland, R.F.D. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereot May 15 1945 (month) (day) (year)

Cemetery or crematory Druid Ridge Cem.

Location Pikesville, Balto. Co. Md

18. Funeral director Landon M. Bishop

Address Sparks, Md.

19. May 13, 45 (Date rec'd by registrar) Wilmer C. Ensor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 12 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 12 1945 to May 12 1945 and that I last saw h.. alive on May 12 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 hrs.
Due to Hypertension	unk.
Due to Arteriosclerosis, Heart	unk.
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death shnuld be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured st work?

23. SIGNATURE Bennett A. Glaser M. D. or other

Address Suitlandville Date signed 5/12/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94

T 05468

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Westchester Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Lewis Franklin Miller

3.(b) Social Security Number: 216-01-1577

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bertie S. Miller
6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Nov. 19, 1880

8. AGE:

Years	Months	Days	If less than one day
64	5	12	...hrs. ...min.

9. Birthplace: Frederick Co. Md.
(Town, county, and state)
10. Usual occupation: Guard
11. Industry or business: Doughnut Corp. of America
FATHER 12. Name: William A. Miller
13. Birthplace: Frederick Co. Md.
MOTHER 14. Maiden name: Mary M. Hose
15. Birthplace: Frederick Co. Md.
16. Informant: Mrs. Bertie S. Miller
Address: Ellicott City, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 4 1945 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Ellicott City, Md.
18. Funeral director: Easton, Md.
Address: Ellicott City, Md.
19. (Date rec'd by registrar) 5/4 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1, 1945 at 9:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/30 1945 to 5/1 1945 and that I last saw h.i.m. alive on 5/1 1945

Immediate cause of death	DURATION
Coronary Thrombosis	10 min.
Due to	
Due to	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: George E. Burtoff M.D. M. D. or other
Address: Elliott City, Md. Date signed: 5/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (17a)

Reg. Dist. No. 30

04765

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 608 Cobernave Road
(d) Length of stay in hospital or inst. (yrs., mos., or days) Life
(e) Length of stay in this community (yrs., mos., or days) Life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Catonsville (If outside city or town limits, write RURAL and give town)
(d) Street No. 608 Cobernave Road (If rural give location)
(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Luther Amos Mitchell

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex Male | 5. Color or race White | 6 (a) Single, married, widowed, or divorced Widower

6 (b) Name of husband or wife Maria Mitchell

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Dec. 20 1856

8. AGE: Years 88 | Months 5 | Days 7 | If less than one day _____ hr. _____ min.

9. Birthplace Baltimore Co. Md. (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Cemetery Employee

FATHER
12. Name William Thomas Mitchell
13. Birthplace Baltimore Co. Md.

MOTHER
14. Maiden Name Mary Lilly Ryan
15. Birthplace Mary land

16 (a) Informant Mrs. Charles A. Hahn
(b) Address 608 Cobernave Road

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 30 45 (month) (day) (year)
(c) Cemetery or crematory Loudon Park Cem.
Location Baltimore Md.

18 (a) Funeral director C. Miller Lamborn
(b) Address 4510 Liberty Heights Ave

19 (a) 5/29/45 (Date rec'd by registrar) (b) H. C. Andreas Deputy Registrar

MEDICAL CERTIFICATION

20. Date of death May 27 1945, at 4-30 a M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb 13 1937, to May 27 1945, and that I last saw him alive on May 27 1945.

Immediate cause of death	Duration
Cardio-Renal Vascular Disease	8 yrs
Due to Myocardial Insufficiency	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature J. N. Dolsaca M. D. or other
Address 617 W 40th St Date signed 5/28/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

P

04766

Reg. Dist. No. 38

1. PLACE OF DEATH:

County: Bellona & Brightside Aves.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? -------

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bellona & Brightside Avenues

(If rural, give LOCATION)

2.(a) If veteran, name war -------

3.(a) FULL NAME: Margaret M. Mooney

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): ----------

8. AGE: Years	Months	Days	If less than one day
About 79	---	---	-- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: -----

FATHER

12. Name: Michael Mooney

13. Birthplace: Ireland

MOTHER

14. Maiden name: Mary Mooney (OK)

15. Birthplace: Ireland

16. Informant: Miss Margaret L. Walsh

Address: 511 N. Monroe Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/7/45 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Baltimore, Maryland

18. Funeral director: H. W. Mears and Son

Address: 805 N. Calvert Street

19. 5/3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/2/45 19.. at 6-30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1943 to 5/2/45 19.. and that I last saw her alive on 4/28/45 19..

Immediate cause of death	DURATION
Coronary Thrombosis	2 Hrs
Due to: Arterio Sclerosis	
Myocarditis	Gradual
Due to: Chr. Endocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. Hardy M. D. or other

Address: 1403 Park Ave Date signed: 5/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

(M) (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

T 04767

Reg. Dist. No. 34

1. PLACE OF DEATH:
County: Baltimore
City or town: Mt Carmel (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Mt Carmel (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lewis E Morfoot.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Georgiana Hall
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Aug 14 - 1867

8. AGE:

Years	Months	Days	If less than one day
77	9	1	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Lewis E Morfoot
13. Birthplace: Md
MOTHER 14. Maiden name: Elizabeth Bowsom
15. Birthplace: Md.
16. Informant: Mrs Lewis E Morfoot
Address: Upperco, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18/45 (month) (day) (year)
Cemetery or crematory: Foreston
Location: Balto Co, Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. 5/17 1945 (Date rec'd by registrar) P E Fowble, Md. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 19 45 at 7:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 19 45 to May 15 19 45
and that I last saw h... alive on May 15 19 45

Immediate cause of death	DURATION
Chronic Myocarditis.	
Due to: Coronary Sclerosis. Cardio Renal	
Vascular Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) —
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Joseph E Bond M.D. M. D. or other
Address: Hampstead Md Date signed: 5-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 04768

Reg. Diat. No. .....

1. PLACE OF DEATH:

County Baltimore

City or town Kensington

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred:

620 S Warwick Rd

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 724 E. North Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Michael Mueller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife late Katherine Bohn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) January 8, 1873

8. AGE: Years	Months	Days	If less than one day
72	4	10	..... hrs. ..... min.

9. Birthplace Baltimore Maryland

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name George Mueller

13. Birthplace Germany

MOTHER 14. Maiden name — Deffner

15. Birthplace Germany

16. Informant Mr Frank L. Mueller

Address 620 S. Warwick Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21, 1945 (month) (day) (year)

Cemetery or crematory Lorraine Park

Location Woodlawn Md

18. Funeral director Harry H Witzke

Address 4101 E Edmondson Ave

19. May 21, 19 45 (Date rec'd by registrar) A. W. Hedrich Registrar

aEV

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 19 45 at 2.55 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16 19 45 to May 18 19 45

and that I last saw him alive on May 18 1945 19 .....

Immediate cause of death	DURATION
Cerebral Haemorrhage	48 hours
Due to Generalized arterio sclerosis with hypertension	Years
Due to	
Other conditions Arterio sclerotic type of heart Dis, with cardiac hypertrophy and congestive failure	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Michel M D

M. D. or other

Address 2901 Edmondson Ave Baltimore Md Date signed May 19 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 04769 P

Reg. Dist. No. YY

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence uf mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, writs RURAL and give nearest town)

Street No. 744 W. Sarahann St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: HORACE S. MURRAY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mrs. Carrie Murray

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): August 10, 1891

8. AGE:	Years	Months	Days	If less than one day
	53	9	5	....hrs. ....min.

9. Birthplace: Talbot Co., Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Thomas H. Murray
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Eliza Smith
15. Birthplace: Maryland

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5 21 1945 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: Katie R. Williams
Address: 321 N. Schroeder St., Balto., Md.

19. 5/21/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1945 at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8, 1945 to May 16, 1945 and that I last saw him alive on May 16, 1945

Immediate cause of death	DURATION
Broncho-Pneumonia	2 Days plus
Due to	
Due to	
Other conditions: Bacterial Endocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: Same as Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT.COL., M.C. M. Brother CLIN. DIR.
Address: Fort Howard, Md. Date signed: 6-17-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04770

CERTIFICATE OF DEATH

Reg. Dist. No. 34

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Rural near Hoffmansville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Rural near Hoffmansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: 2

3.(a) FULL NAME: Edward Paul Mustin
3.(b) Social Security Number: None

4. Sex: Mail
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Blair Mustin
6.(c) If alive, give age: 42 years
7. Birth date of deceased (mo., day, yr.): Jan. 20, 1892

8. AGE: Years: 53 | Months: 3 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Pittsburgh Penna.
(Town, County, and state)
10. Usual occupation: Marble Polisher
11. Industry or business:
FATHER 12. Name: Louis Mustin
13. Birthplace: Unknown
MOTHER 14. Maiden name: Nellie Driscoll
15. Birthplace: Unknown
16. Informant: Edward Paul Mustin Jr.
Address: Miller's Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5-10-45 (month) (day) (year)
Cemetery or crematory: Cemetery Baltimore Co.
Location: St. Peters Church Balto. Co.
18. Funeral director: Jacob Winkler Sons
Address: Manchester, Md.
19. May 9 1945 (Date rec'd by registrar) Basil E. Fendall M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1945, at 3 1/2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to May 7 1945
and that I last saw h. alive on May 7 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A. W. France M. D. or other
Address: Fawkton, Md. Date signed: 5/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04771

Reg. Dist. No. 41

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:
Veterans Administration Facility

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Luzerne

City or town: Pittston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II V

3. (a) FULL NAME: ROBERT G. NOONE

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lorraine P. Noone

6.(c) If alive, give age: 22 years

7. Birth date of deceased (mo., day, yr.): January 27, 1919

8. AGE:	Years	Months	Days	If less than one day
	26	3	4	...hrs. ...min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: Draftsman

11. Industry or business

FATHER — 12. Name: John Noone

FATHER — 13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Agnes Golden

MOTHER — 15. Birthplace: Pennsylvania

16. Informant: Clinical Records, Veterans Administration, Fort Howard, Md.
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 5, 1945 (month) (day) (year)

Cemetery or crematory: St. John's Cemetery

Location: Pittston, Pa.

18. Funeral director: A. Lee Oder

Address: 4644 York Road, Balto. Md.

19. 5/2/45 (Date rec'd by registrar) 19... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 45 at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 19 45, to May 1 19 45 and that I last saw him alive on May 1 19 45

Immediate cause of death	DURATION
UREMIA	25 ds plus
Due to: Nephritis, parenchymatous, chronic	
Due to:	
Other conditions: Disease of Heart, nephritic pericarditis	17 days

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Chronic glomerular nephritis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: for A.M. Balter
A.M. BALTER, LT. COL., M.C. CLIN. D. DIRECTOR

Address: Ft. Howard, Md. Date signed: 5/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

04772 P

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 13 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4233 Shamrock Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Ohlhart

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Charles Ohlhart

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): September 1, 1885

8. AGE: Years	Months	Days	If less than one day
59	9	21	...hrs. ...min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Karl Hacker

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Augusta Recker

MOTHER — 15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof May 26 - 45 (month) (day) (year)

Cemetery or crematory: Balto. Cem.

Location: North Ave & Gay St.

18. Funeral director: John L. Miller

Address: 2334 Jefferson St.

19. 6/25 19 45 (Date received by registrar) C. W. Sedwick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 19 45, at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 9 19 45, to May 22 19 45 and that I last saw h...er...alive on May 22 19 45

Immediate cause of death	DURATION
Terminal pneumonia	24 hours
Due to: Chronic myocardial insufficiency Indef.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robert E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

04773

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Balto.
City or town Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No. Chatsworth Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME Elizabeth E. Penn

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James H. Penn
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 4, 1860

8. AGE: Years	Months	Days	If less than one day
84	9	23	..... hrs. ..... min.

9. Birthplace Balto. City
(Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name Rev. Thomas Nichols
13. Birthplace Md.
MOTHER 14. Maiden name Keziah Jane Wells
15. Birthplace Md.
16. Informant T. Harry Penn
Address Glyndon, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 1945 (month) (day) (year)
Cemetery or crematory Camp Chapel
Location Balto. Co.
18. Funeral director J. F. Eline & Sons
Address Reisterstown, Md.
19. May 29 1945 (Date rec'd by registrar) Mary B. Eline Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-22-'37 19..., to 5-27 1945
and that I last saw h.e.r. alive on 5-17 1945

	DURATION
Immediate cause of death: Coronary Occlusion	10 min.
Due to: Arteriosclerosis	2 yrs.
Due to:	
Other conditions: Chronic Lithiasis	5 yrs.
Hypertensive C-V Disease	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: No
Date of op. .....
Autopsy results: ne.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE D. D. Eagles, M.D. M. D. or other
Address Reisterstown, Md. Date signed 5-31-'45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 04774

P

1. PLACE OF DEATH:

County: Baltimore

City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
3622 Milford Mill Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Balto.

City or town: Rockdale
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3622 Milford Mill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

HARVEY PHILLIPS

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Blanch M. Phillips

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 24, 1882

8. AGE: Years	Months	Days	If less than one day
62	9	14	..... hrs. ..... min.

9. Birthplace: Carroll Co., Md.
(Town, county, and state)

10. Usual occupation: Barber

11. Industry or business

FATHER
12. Name: Thomas Phillips
13. Birthplace: Md.

MOTHER
14. Maiden name: Susanna Goodwin
15. Birthplace: Md.

16. Informant: Mrs. Blanch M. Phillips
Address: 3622 Milford Mill Rd., Rockdale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/11/45 (month) (day) (year)

Cemetery or crematory: Lorraine Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5/11/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8, 1945, at 7:20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 1940, to MAY 8 1945

and that I last saw h... alive on MAY 8 1945

Immediate cause of death	DURATION
Arteriosclerotic Cardiovascular	
heart disease	7
Due to	
Due to	
Other conditions: Parkinsonian's Disease	2

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Ben A. Kochman, M.D.
M. D. or other

Address: 392 Edmondson Ave. Date signed: 5/10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

04775 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore (21)
(If ontside city or town limits, write RURAL and give nearest town)

Street No.: Box 364 Route #16
(If rural, give LOCATION)

2.(a) If veteran, name war: SAW

3. (a) FULL NAME: SALVADOR P. POLIGARDO

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Salvadora Josephine Poligardo

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): 5-29-74

8. AGE: Years	Months	Days	If less than one day
70	11	13	....hrs. ....min.

9. Birthplace: Italy
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER 12. Name: Dominico Poligardo

FATHER 13. Birthplace: Italy

MOTHER 14. Maiden name: Conchita ?

MOTHER 15. Birthplace: Italy

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16 45 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Maryland

18. Funeral director: James J. Bruzdzinski
Address: 1407 Eastern Ave., Essex, Md.

19. 5/14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12, 1945, 6:05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6, 1945 to May 12, 1945 and that I last saw him alive on May 12, 1945

	DURATION
Immediate cause of death: Hemorrhagic cystitis	
Due to: Prostatic Hypertrophy	
Due to:	
Other conditions: Peritoneal adhesions with partial obstruction of the colon	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C. CLAIM, or DIRECTOR
Address: Fort Howard, Md. Date signed: 5-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

04776

Reg. Dist. No. 38

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Balto.
City or town: Towson Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred: 11 Prospect Hill
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. 11 Prospect Hill - Towson Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Purvines

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Married

6.(b) Name of husband or wife: Albert Purvines
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 18, 1896

8. AGE: Years	Months	Days	If less than one day
48	8	2	hrs. min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. Name of father: Charles Johnson
13. Birthplace of father: Md.
14. Maiden name of mother: Mary Burns
15. Birthplace of mother: Md.
16. Informant: Albert Purvines
Address: 11 Prospect Hill - Towson Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-23-45 (month) (day) (year)
Cemetery or crematory: Pleasant Rest
Location: Towson, Md.
18. Funeral director: Archibald A. Gaddis
Address: 2101 McCulloh St. Balto-17-Md.
19. 5/24/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20 19 45, at 5a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 44, to May 20 19 45 and that I last saw her alive on May 19 - 45 19

Immediate cause of death	DURATION
Chronic Duodenal Ulcer	1 - 6 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Louis A. Johnson M.D. M. D. or other
Address: 2229 Greenspring Ave. Date signed: May 22 1945

BC 04778 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 31 yrs 9 mos 10 days
Hospital, institution, or street address where death occurred: Crownsville State Training School
How long in hospital or institution? 31 yrs 9 mos 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 883 W. Lombard St.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: George W Ram

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	S.

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 10/19/'06

8. AGE:

Years	Months	Days	If less than one day
38	6	21	hrs. min.

9. Birthplace: Baltimore, Md (Town, county, and state)
10. Usual occupation: Inmate
11. Industry or business:
12. FATHER — Name: William Ram
13. FATHER — Birthplace: Pa
14. MOTHER — Maiden name: Bessie New
15. MOTHER — Birthplace: Md.
16. Informant: Institutional Records
Address: Owings Mills, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet - Cemetery
Location: Frederick Md.
18. Funeral director: John J. Corcoran & Son
Address: 901 Hollins St.
19. 5/14/45 (Date rec'd by registrar) Adv. Hebrel D. R. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11, 1945, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 May 1945, to 11 May 1945
and that I last saw h..m alive on 11 May 1945

Immediate cause of death	DURATION
Coronary Thrombosis	immediate
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. B. Butler M. D. or other
Address: Owings Mills, Md. Date signed 5/11/45

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STATE OF MARYLAND—CERTIFICATE OF DEATH

04779

1. PLACE OF DEATH

County Baltimore Registration Dist. No. 04 33

Village or City Woodensburg No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Frederick Reigler

(a) Residence: No. Woodensburg, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M	W	married

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of Estey Reigler (maiden name Bosley)

6. DATE OF BIRTH (month, day, and year) May 20 1874

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	29	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Farmer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Farming

10. Date deceased last worked at this occupation (month and year) May 1945

11. Total time (years) spent in this occupation 50 yrs

12. BIRTHPLACE (city or town) (State or country) Woodensburg - Balto Co. Md

FATHER

13. NAME George Reigler

14. BIRTHPLACE (city or town) (State or country) not known

MOTHER

15. MAIDEN NAME first name not known Ent. Price

16. BIRTHPLACE (city or town) (State or country) not known

17. INFORMANT Mrs Estey Reigler

(Address) Woodensburg, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Mt. Lilead Woodensburg Date May 26, 1945

19. UNDERTAKER Mc Kerrigan & Sons

(Address) Reisterstown, Md.

20. FILED 5/25/1945 Mary B. Elins

Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 23rd (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 22, 1945, to May 23, 1945

I last saw him alive on May 23, 1945; death is said to have occurred on the date stated above, at 4 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Acute dilatation Heart (Mustang)	
(Chronic myocarditis)	

Other Contributory Causes of importance:

Chronic Rheumatism

" arterio-sclerosis.

Arrythmia; Tachycardia; Vomiting.

Name of operation Dyfemia Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Cyril E. Fowble M. D.

(Address) Upperco, Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

04780 T

Reg. Dist. No. 32

1. PLACE OF DEATH:

County: Baltimore

City or town: Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Mt. Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Smith Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Wesley Ritter

3. (b) Social Security Number: -

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ----

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Feb. 15, 1882

8. AGE: Years	Months	Days	If less than one day
63	2	20	____ hrs. ____ min.

9. Birthplace: Baltimore Co., Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Oliver Richard Ritter
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden name: Julia Ann Keller
15. Birthplace: Baltimore County, Maryland

16. Informant: Miss Elizabeth Ritter (Sister)
Address: Smith Ave., Mt. Washington-Balto.Co. Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: May - 8 -1945
(month) (day) (year)

Cemetery or crematory: Saters Church Cemetery

Location: Falls Road

18. Funeral director: Frank H. Newell

Address: Pikesville, Maryland

19. 5 - 7 - 45
(Date rec'd by registrar)
Dr. E. E. Nichols
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 19 45, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15, 1944, to May 5, 1945 and that I last saw him alive on May 5, 1945

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to: Arterio Sclerosis	?
Due to:	
Other conditions: Chronic Bronchial Asthma and Bronchitis	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. E. Nichols M. D. or other

Address: Pikesville-8, Md. Date signed: 5/7/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-C)

CERTIFICATE OF DEATH

BC P

04777

Reg. Dist. No. 42

1. PLACE OF DEATH:

County: Baltimore County

City or town: Rural Relay Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs & 5 days.

Hospital, Institution, or street address where death occurred:

Relay Sanitarium

How long in hospital or institution? 5 yrs & 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: [redacted] 00

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2423 East Madison St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Margaret anna Ritterpusch

3.(b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband ~~or wife~~: CONRAD RITTERPUSCH

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 31, 1871

8. AGE:

Years	Months	Days	If less than one day
74	1	18	....hrs. ....min.

9. Birthplace: ? Germany (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: home

FATHER — 12. Name: George Schueller

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Margaret Miller

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. George P. Schueller

Address: 20 West Rolling Road Catonsville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-21-45 (month) (day) (year)

Cemetery or crematory: Druid Ridge Cemetery

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. 5/21/45 (Date rec'd by registrar) C. W. Ledrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1945, at 6. P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1st 1944 to May 17th 1945 and that I last saw h[redacted] alive on May 17th 1945.

Immediate cause of death	DURATION
Cardio Respiratory failure	
Due to: Coronal Sclerosis	
Due to: Age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Cliff Ratliff Jr. M.D. M. D. or other

Address: St. Agnes Hospital Date signed: May 18 1945

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

04781

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:

County Balto.

City or town Overlea

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.

City or town Overlea Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 E. Mapel Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alfred D. Roesch

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 6 1943

8. AGE: Years 1 | Months 7 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Balto. (Town, county, and state)

10. Usual occupation

11. Industry or business None.

FATHER 12. Name Alfred Roesch

13. Birthplace Germany

MOTHER 14. Maiden name Cecilia Granitz

15. Birthplace Pa.

16. Informant Alfred Roesch

Address 2 E. Mapel Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/2/45 (month) (day) (year)

Cemetery or crematory Mt. Red corner

Location Belair Rd.

18. Funeral director M. W. E. Dippel's Sons

Address 7410 Belair Rd.

19. 6/1 1945 A. W. Hedrick Jr. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27 1945 to May 31 1945

and that I last saw h... alive on May 31 1945

	DURATION
Immediate cause of death	
Acute Bronchial Pneumonia	5/25/45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Brown M.D.

M. D. or other

Address 1663 W. North Ave. Date signed 5/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Brown
1663 W N.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

04782 T

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month 17 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution? 1 month 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Forrestville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Ward Ryon

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Isabelle Condi

Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11, 1859

8. AGE: Years	Months	Days	If less than one day
85	10	17	..... hrs. ..... min.

9. Birthplace: Forrestville, Maryland (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Agriculture

FATHER 12. Name: Thomas Ryon

13. Birthplace: Maryland

MOTHER 14. Maiden name: Susan Frye

15. Birthplace: Maryland

16. Informant: Hospital Records, Spring Grove State Hospital, Catonsville, 28, Md.

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 6 45 (month) (day) (year)

Cemetery or crematory: Forestville Md

Location: Forestville Prince Geo Co Md

18. Funeral director: Gutschow Bros

Address: Upper Marlboro Md

19. 5/6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 19 45 at 11:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 19 45 to May 6 19 45 and that I last saw him alive on May 6 19 45

Immediate cause of death	DURATION
Cerebral Thrombosis	72 hours
Due to: Chronic arteriosclerotic cardiovascular disease	Indef.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C.A. Mead M.D.

Henry C.A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed 5/6/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore — Reg. Dist. No. 33 P

CERTIFICATE OF DEATH

04783

1. PLACE OF DEATH:
(a) County: Baltimore
(b) City or town: Pentertown (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Ft. Pleasant
(d) Length of stay in hospital or inst. (yrs., mos., or days):
(e) Length of stay in this community (yrs., mos., or days):

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State: Maryland (b) County:
(c) City or town: Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 343 Mason Court (If rural give location)
(e) If foreign born, how long in U. S. A.? 8 years

3 (a) **FULL NAME** Faye Ryman Ryman

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife: —

6. (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Sept 5, 1926

8. AGE: Years: 18 | Months: 8 | Days: 18 | If less than one day: hr. min.

9. Birthplace: Poland (Town, county, and state)

10. Usual occupation: Student

11. Industry or business

FATHER
12. Name: Abraham Ryman
13. Birthplace: Poland

MOTHER
14. Maiden Name: Ruth Engel
15. Birthplace: Poland

16 (a) Informant: Ruth Kadish (mother)
(b) Address: 343 Mason Court

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 5-24-45 (month) (day) (year)
(c) Cemetery or crematory: ROSEDALE
Location: PHIL RD + HAMILTON AVE

18 (a) Funeral director: JACK LEWIS INC
(b) Address: 1439 E. BALTO ST

19 (a) 5/23/45 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. Date of death: May 23, 1945, at 6 53 A M

21. I certify that death occurred on the date above stated; that I attended deceased from June 23, 1942 to May 23, 1945 and that I last saw him alive on May 23, 1945.

Immediate cause of death	Duration
Myocardial Collapse	
Due to: Pulmonary Tuberculosis	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide:
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury:

23. Signature: Albert D. Shaver M. D. or other
Address: Pentertown Road Date signed: May 23, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23a

CERTIFICATE OF DEATH

04784 P

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 mo
Hospital, institution, or street address where death occurred:
Rosewood State Training School
How long in hospital or institution? Employed since 3/25/44

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Pikesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 210 Church Lane
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: William Henry Schaeffer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Mary Eliz. Schaeffer
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 9, 1881

8. AGE: Years 63 | Months 9 | Days 27 | If less than one day: ____ hrs. ____ min.

8. Birthplace: Maryland (Balto Co)
(Town, county, and state)

10. Usual occupation: attendant, Rosewood State

11. Industry or business: Training School, Owings Mills

FATHER
12. Name: George Schaeffer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ann Dorzer
15. Birthplace: Maryland

16. Informant: Mrs. Helen Lehman (Daughter)
Address: 3527 Utopia Parkway Flushing, L.I. N.Y.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-9-45 (month) (day) (year)

Cemetery or crematory: Loudon Park
Location: Baltimore City

18. Funeral director: Harry H. Ritzke
Address: 4101 Edmondson Ave Balto Md

19. 5/8/45 (Date rec'd by registrar) Dilo Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1945 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 6 1945 and that I last saw him alive on May 6 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 da
Due to: Arteriosclerosis & Hypertension	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: George C. Medairy M.D.
M. D. or other
Address: Owings Mills, Md Date signed: 5/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04785

Reg. Dist. No.

1. PLACE OF DEATH:
County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
1901 Alto-Vista Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Woodlawn
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1901 Alto Vista Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: CHARLES EDWARD SCHAUMLOEFFEL, SR.

3. (b) Social Security Number: 218-14-0327

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary J. Schaumloeffel
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 9, 1883

8. AGE: Years	Months	Days	If less than one day
62	0	4	..... hrs. ..... min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: Lawyer
11. Industry or business: Self

FATHER
12. Name: Nicholas Schaumloeffel
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Rosina
15. Birthplace: Basil, Switzerland

16. Informant: Mr. Charles E. Schaumloeffel, Jr.
Address: 6712 Dogwood Rd., Woodlawn, 7, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/16/45 (month) (day) (year)
Cemetery or crematory: Lorraine Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 5/14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1945, at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from from Jan. 15, 1945. to May 13 1945. and that I last saw him alive on May 12, 1945.

	DURATION
Immediate cause of death: Coronary occlusion	9 hrs.
Due to: Arteriosclerosis	??
Due to: Myocarditis	about 6 mo.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Walter D. Tickner M. D. or other
Address: 2220 Garrison Blvd. Date signed: 5/14/45.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (945)

Registered No. 42

04786

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County
(a) Baltimore City, Maryland
(b) Street address 2708 Tennessee Ave
(c) Hospital or institution: Rosemont,
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County Balto
(c) City or town Rosemont
(If outside city or town limits, write RURAL and give town)
(d) Street No. 2708 Tennessee Ave
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Emma L Scheib

3 (b) If veteran, name war —

3 (c) Social Security Account No. —

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
M	W	married

6 (b) Name of husband or wife W H

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 7-4-[illegible]86

8. AGE: Years	Months	Days	If less than one day
61	8	13	hr. min.

9. Birthplace Md
(Town, county, and state)

10. Usual Occupation Housewife

11. Industry or business

FATHER
12. Name W H Lester
13. Birthplace Md.

MOTHER
14. Maiden Name Emma Scarborough
15. Birthplace Md

16 (a) Informant W H Scheib
(b) Address 2708 Tennessee Ave

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/19/45 (month) (day) (year)
(c) Cemetery or crematory Westport
Location Edmondson

18 (a) Funeral director Edward Loudon
(b) Address 2359 Wash Blvd

19 (a) May 18 45 (Date rec'd by registrar) (b) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 1945, at 10P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 13 1945, to May 16 1945, and that I last saw h[illegible] alive on May 15 1945

Immediate cause of death	Duration
Coronary Thrombosis	2 days
Due to	
Due to	
Other Conditions Hypertension — (Include pregnancy within 3 months of death)	
Date of operation	
Major findings of operation:	
of autopsy:	

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [signature] M. D.
Address [illegible] Date signed 5/19/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

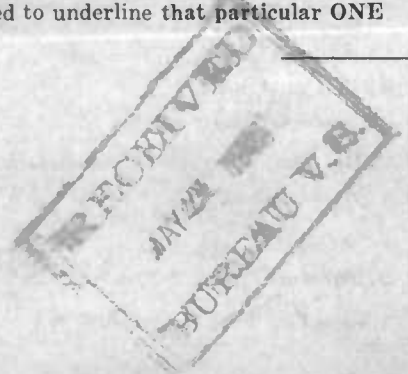
If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04787

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 3 months, 7 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 2 years, 3 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore-30
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 420 South Durham Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sarah Schirmer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

B.(b) Name of husband or wife: William Schirmer
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 24, 1867

8. AGE:	Years	Months	Days	If less than one day
	78	-	-	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Henry Mitchell
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Charlotta Douglas Sterling
MOTHER 15. Birthplace: Scotland
18. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/26/45 (month) (day) (year)
Cemetery or crematory: Oaklawn
Location: Eastern Ave. & V.
18. Funeral director: Lilly & Gutke Bros.
Address: 403 S. Wolfe St.
19. 5/24 19 45 (Date rec'd by registrar) D. C. Andrews Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24, 1945 19 at 9:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 17 19 43 to May 24 19 45 and that I last saw her alive on May 24 19 45

Immediate cause of death	DURATION
Chronic myocardial insufficiency	-Indef.
Due to: Arteriosclerotic cardiovascular disease	Indefinite
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 5/24/45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 926

CERTIFICATE OF DEATH

1 04788

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Baltimore
City or town: Rodgers Forge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Rodgers Forge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 Murdock Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth G. Schmalzer

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Wm. J. Schmalzer
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 20. 1884

8. AGE: Years	Months	Days	If less than one day
60	4	28	..... hrs. ..... min.

9. Birthplace: Balto. Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Samuel L. Horney
13. Birthplace: Balto. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Balto. Md.

16. Informant: Miss Madaline Schmalzer
Address: 206 Murdock Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21/45 (month) (day) (year)
Cemetery or crematory: Parkwood Cem.
Location: Balto. Md
18. Funeral director: Philip Henry & Sons
Address: 2024 Orleans St.

19. May 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18/45 19..... sf..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 19 44, to May 18 1945 and that I last saw ... alive on May 18 1945

	DURATION
Immediate cause of death: Arteria Sclerosis	unknown
Pulmonary Edema	24 hrs
Due to: Chronic Mitral Endocarditis	unknown
Hypertension	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. B. Emrich M. D. or other
Address: 7201 York Rd Balto 17. Date signed 5-19-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89a)

CERTIFICATE OF DEATH

04789 P

Reg. Dist. No. 43

1. PLACE OF DEATH:
County: Baltimore (118 Belmar Avenue)
City or town: Overlea
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1602 N. Durham Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Margaret M. Schoenberger

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Nicholas Sshoenberger
6.(c) If alive, give age: D years

7. Birth date of deceased (mo., day, yr.): July 30, 1864

8. AGE: Years	Months	Days	If less than one day
80	9	8	..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mr. William F. Schoenberger (Son)
Address: 118 Belmar Avenue, Balto: Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11th, 1945 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: 4430 Belair Rd. Balto: Md.
18. Funeral director: George J. Ruth, Inc.
Address: 1735 Harford Avenue

19. 5/9/45 (Date rec'd by registrar) A. W. Hedwil D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8th 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1945, to May 8 1945
and that I last saw her alive on May 7 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Jacob Fisher M. D. or other
Address: 1825 N. Wash St. Date signed: 5/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-f)

CERTIFICATE OF DEATH

04790 P

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Balto #24 (Near Govans)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Off 418 Oriole ave
How long in hospital or institution? 5 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Balto #24 (Near Govans)
(If outside city or town limits, write RURAL and give nearest town)
Street No. Off 418 Oriole ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Albert J. Seebode

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widower

6.(b) Name of husband or wife: Julia Seebode

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 4/14/1880

8. AGE: Years: 65 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Balto Md.
(Town, county, and state)

10. Usual occupation: Photographer

11. Industry or business:

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Wm. Heft Cousin
Address: 413 Northern ave

17. Burial, cremation, or removal. Which? Burial. Date thereof: June 1 1945 (month) (day) (year)
Cemetery or crematory: Sacred Heart of Mary
Location: Balto Co

18. Funeral director: James L Boydenstine
Address: 1407 Eastern Ave Rd Essex

19. 6/1 1945 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945 at 1A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1945 to May 30 1945 and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Carcinoma throat	
Due to	
Due to Hemorrhage	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: M L Carmine M.D.
Deputy Medical Examiner
M.D. or other
Address: Randall Md. Date signed: 6-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

BC T 04791

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County Baltimore
City or town Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: Mrs. Hoods Nursing Home
How long in hospital or institution? 5313 Edmondson Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1002 Wilmington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bertha H. Shaffer

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Single

6.(b) Name of husband or wife
6.(c) If e1ive, give age years
7. Birth date of deceased (mo., day, yr.) June 11, 1896

8. AGE:

Years	Months	Days	If less than one day
48	11	2	hrs. min.

9. Birthplace Balto. Md (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name Henry G. Shaffer
13. Birthplace Pa.
MOTHER 14. Maiden name Anna M. Yeatman
15. Birthplace Va.
16. Informant Henry G. Shaffer
Address 1002 Wilmington Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16/45 (month) (day) (year)
Cemetery or crematory Western
Location Edmondson ave. + Longwood
16. Funeral director Harry A. Mitchell
Address 4101 E Edmondson Ave.
19. 5/15/45 (Date rec'd by registrar) H. C. Andrews Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1945, at 3 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to May 13 1945
and that I last saw h alive on May 13 1945
Immediate cause of death Carcinoma of Breast — DURATION 1 yr.
Due to
Due to
Other conditions
(Includa pregnancy within 3 months of death)
Major findings of operations T.A. & Breast C
The Tea Tarm Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jesse M Bowers M. D. or other
Address Catonsville Date signed 5/15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

04792

CERTIFICATE OF DEATH

Reg. Diat. No. 38

1. PLACE OF DEATH:
County: Balto.
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
6900 Petworth Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto.
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6900 Petworth Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs Cora T. Sheppard. (Cora Trusty Sheppard)

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Benjamin Sheppard
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 21, 1887

8. AGE: Years	Months	Days	If less than one day
57	8	0	hrs. min.

9. Birthplace: Balto., Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Samuel Christopher
13. Birthplace: Balto., Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mr. Benjamin Sheppard
Address: 6900 Petworth Road

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/23/45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS
Address: Balto., Md.

19. 5/24 (Date rec'd by registrar) 1945 A. M. Kedrick Registrar
D. M.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/21 st 1945 4 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 4th 1944 to May 21 st 1945
and that I last saw her alive on May 21 st 1945

Immediate cause of death	DURATION
Pulmonary Carcinoma	5 mths.
Due to Breast Carcinoma	2 yrs.
Due to Cause not known	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Amelia E. Link M. D.
M. D. or other
Address: 2211 E Lake Ave Date signed: 5/21/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-6)

04793

CERTIFICATE OF DEATH

Reg. Dist. No. 44

VS A15 (1) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Balto County

City or town: Cuddle River Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto

City or town: Cuddle River

(If outside city or town limits, write RURAL and give nearest town)

Street No. 852 K Wilson Pk. Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emma Cecelia Shuster

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Horace W. Shuster

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): 12-19-1869

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
75 75	5	5		

9. Birthplace: Philadelphia Penna (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Charles A Bretzinger

13. Birthplace: unknown

MOTHER 14. Maiden name: Snyder

15. Birthplace: Unknown

16. Informant: Mrs. Horace W. Shuster

Address: 852K Wilson Pk. Rd.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 5-24-45 (month) (day) (year)

Cemetery or crematory: Philadelphia

Location: Penna.

18. Funeral director: Wm. J. Fichner & Son

Address: North & Penna Ave

19. May 24 1945 (Date rec'd by registrar) John J. Connelly Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1945 at 2.10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1943 to May 24 1945 and that I last saw h... alive on May 23 1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	4 days
Due to: Arteriosclerosis	15 yrs.
Due to:	
Other conditions: Diabetes Mellitus	15 yrs.
Carcinoma of Uterus (Include pregnancy within 3 months of death)	8 yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John C Baier (M.D.) M. D. or other

Address: 815 Eastern Ave Date signed: 5-24-45

Balto 24

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (41)

04794

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:
County Balto Co Md
City or town Pikesville Balto Co Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, Institution, or street address where death occurred: Woodholme Rd Pikesville Balto Co
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto
City or town Pikesville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. Woodholme Rd Pikesville
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Fannie Frank Skutch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) ~~Single~~, married, widowed, ~~or divorced~~
Female	White	Widowed

6.(b) Name of husband or wife: Max Skutch
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 10 1850

8. AGE: Years 94 | Months 7 | Days 15 | If less than one day ..... hrs. ..... min.

9. Birthplace: Germany (Town, county, and state)

10. Usual occupation: House Work

11. Industry or business

FATHER 12. Name: David Frank
13. Birthplace: Germany

MOTHER 14. Maiden name: Babara Houseman
15. Birthplace: Germany

16. Informant: Mrs Sidney M Cone
Address: Woodholme Rd Pikesville Balto Co

17. Burial (Burial, cremation, or removal; which?) Date thereof 5/27/45 (month) (day) (year)
Cemetery or ~~cemetery~~: Balto Hebrew
Location: Belair Rd

18. Funeral director: David Sondheim & Son
Address: 1902 Eutaw Place

19. 5-26-1945 (Date rec'd by registrar) Dr. E. E. Nichol Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 25 1945 at 5 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1905 19.. to May 25 1945 and that I last saw her alive on May 18 1945

Immediate cause of death	DURATION
Congestive heart failure	5 mos
54 mph + gus	
Due to: Arteriosclerotic heart disease	
Due to: Generalized arteriosclerosis	7 yrs
Hypertension - Known	
Other conditions: Diabetes mellitus	7 yrs +

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis P. Hamburger, M. D. or other
Address: 1207 Eutaw Place Date signed: 5-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for addition of usual residence of deceased is shown on FILM No G 95 JUN 1 1945

T 04795

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 182

1. PLACE OF DEATH:
County: Baltimore
City or town: Upper Falls. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Upper Falls, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. -- (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Anna Regina Smith **3.(b) Social Security Number:**

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: W. Kemp Smith
6.(c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Aug 15 1909.

8. AGE: Years: 37 | Months: 2. | Days: 22. | If less than one day: hrs. min.
9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business: Home
FATHER — 12. Name: John Shanahan
FATHER — 13. Birthplace: Md.
MOTHER — 14. Maiden name: Anna L. Keamey
MOTHER — 15. Birthplace: Md.
16. Informant: Mr Kemp Smith
Address: Upper Falls Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 26, 45 (month) (day) (year)
Cemetery or crematory: St Johns.
Location: Long Green Md.
18. Funeral director: Holbrook & Gross.
Address: Bensor, Md.
19. 5/25/45 (Date rec'd by registrar) Priscilla Forwood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1945 at 12 15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925 to May 15 1945 and that I last saw h[illegible] alive on May 15 1945

Immediate cause of death	DURATION
Carcinoma general – Lungs	
Spine – Stomach –	
Due to Primary in left breast	
3½ yrs ago	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Bel Air Md Date signed 6/25/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48a)

CERTIFICATE OF DEATH

04796 P

Reg. Dist. No.

1. PLACE OF DEATH:
County: Baltimore
City or town: Woodlawn (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 5703 Gwynn Oak Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Balto.
City or town: Woodlawn (If outside city or town limits, write RURAL and give nearest town)
Street No.: 5703 Gwynn Oak Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: FLORENCE IRENE SMITH

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Robert Ream Smith 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1879

8. AGE: Years	Months	Days	If less than one day
66	1	17	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business
12. FATHER — Name: Alexander Cromwell
13. FATHER — Birthplace: Balto., Md.
14. MOTHER — Maiden name: Mary C. Sullivan
15. MOTHER — Birthplace: Balto., Md.
16. Informant: Mr. Robert T. Smith
Address: 3111 Royston Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/30/45 (month) (day) (year)
Cemetery or crematory: Loudon Park Cem.
Location: Balto., Md.
18. Funeral director: WM. J. TICKNER & SONS
Address: Baltimore, Md
19. 5/28/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27, 1945, at 12:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1945 to May 27 1945 and that I last saw h[illegible] alive on May 26 1945

Immediate cause of death	DURATION
Carcinoma of Larynx	1 yr.
Due to: Secondary Anemia	
Due to: Starvation (Loss of Appetite)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: 4509 Roberts Pkwy Balto Md Date signed: 5-29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

CERTIFICATE OF DEATH

04797 P

Reg. Dist. No. 30

1. PLACE OF DEATH: Baltimore Co.
County Catonsville
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, Institution, or street address where death occurred: 136 Winters Lane
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Catonsville
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 136 Winters Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Soloman Smith

3.(b) Social Security Number

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): March 1, 1893
8. AGE: Years: 52 | Months | Days | If less than one day: hrs. min.
9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: Henry Smith
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary Ann
15. Birthplace: Va.

16. Informant: Katie Scott
Address: 136 Winters Lane
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-11-45 (month) (day) (year)
Cemetery or crematory: Bella
Location: Maryland
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave
19. 5/10/45 (Date rec'd by registrar) A.W. Wedrick D.M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7, 1945, at 9 45 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to May 7 1945 and that I last saw him alive on May 7 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to	
Other conditions	

(Include pregnancy with in 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. D. Woolridge MD
M. D. or other
Address: Ellicott City Md Date signed 7-9-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

P 04798

Reg. Diat. No. X X

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 71 Days

Hospital, Institution, or street address where death occurred:
Vets. Adm. Facility, Fort Howard, Maryland

How long in hospital or institution? 71 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1310 N. Mount St.,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-I

3. (a) FULL NAME: WILLIAM A. SMITH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Margaret C. Smith

6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 5-11-95

8. AGE: Years	Months	Days	If less than one day
50		2	hrs. min.

9. Birthplace: Richmond, Virginia
(Town, county, and state)

10. Usual occupation: Porter

11. Industry or business:

FATHER
12. Name: Richard Smith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Elizabeth Brown
15. Birthplace: Virginia

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-18-45 (month) (day) (year)

Cemetery or crematory: Richmond Va

Location: Va

18. Funeral director: Thomas E. Kelson

Address: 1303 Presstman, Balto., Md.

19. 5/15 (Date rec'd by registrar) 19 45 [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1945, at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 4, 1945, to May 14, 1945 and that I last saw him alive on May 14, 1945

Immediate cause of death	DURATION
Uremia, Acute	1 Month
Due to: Nephrosclerosis	plus.
Due to:	Unknown
Other conditions: Disease of the Heart, Hypertension & coronary arteriosclerosis Myocardial insufficiency	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] A.M. BALTER, LT.COL., M.C. CLIN. DIR.

Address: Fort Howard, Maryland Date signed: 5-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04799

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years 10 months 20 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 25 yrs. 10 mos. 20 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 128 South Exeter St.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie Snyder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Unknown - Snyder

6.(c) If alive, give age: Deceased years

7. Birth date of deceased (mo., day, yr.): 1886

8. AGE: Years	Months	Days	If less than one day
59	?	?	hrs. min.

9. Birthplace: Russia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Hyman Goldberg

13. Birthplace: Russia

MOTHER

14. Maiden name: Rachel Tarclasky

15. Birthplace: Russia

16. Informant: Hospital records, Spring Grove State Hospital, Catonsville, 28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-25-45 (month) (day) (year)

Cemetery or crematory: Bnai Israel.

Location: Southern Ave Baltic City

18. Funeral director: Jack Lewis Inc.

Address: 1439 E. Baltic. St

19. 5/24/45 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION 4:10 pm

20. DATE OF DEATH: May 24, 1945 19 at 4: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4, 1919 19 to May 24 19 45 and that I last saw her alive on May 24, 1945 19

	DURATION
Immediate cause of death: Liver cyst (etiology unknown)	2 mos.
Due to: Chronic myocardial insuffic.	Indef.
Due to:	
Other conditions:	

(Incinde pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Henry C. A. Mead M.D.

Henry C. A. Mead, M. D. M. D. or other

Address: Catonsville, 28, Md. Date signed: 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

0481P

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Balto.
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Hospital, Institution,~~ or street address where death occurred:
2626 Yorkway
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Balto
City or town: Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2626 Yorkway
(If rural, give LOCATION)
2.(a) If veteran, name war: W

3.(a) FULL NAME: Ethel P. Sraver

3.(b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Frank W. Scraven
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 13th 1893

8. AGE: Years	Months	Days	If less than one day
51	8	11	..... hrs. ..... min.

9. Birthplace: Mass
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Thomas W. Turner
13. Birthplace: England

MOTHER
14. Maiden name: Elizabeth Tott
15. Birthplace: England

16. Informant: Frank W. Sraver
Address: 2626 Yorkway Dundalk

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/45 (month) (day) (year)
Cemetery or crematory: Oak Lawn
Location: Baltimore Co. Md.
18. Funeral director: Mahoney Funeral Home
Address: 1214 E. Fayette St.

19. 5/26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24 1945, at 1:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1st 1944, to May 24 1945
and that I last saw h.. alive on May 24 1945

Immediate cause of death	DURATION
Hypertensive Cardio-vascular	
Due to: Disease	3yrs
Due to:	
Other conditions: Cerebral Hemorrhage	2 hours

(Include pregnancy within 3 months of death)

Major findings of operations: no
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James F. White M.D.
M. D. or other
Address: 6601 Eastern Ave. Baltimore 24, Md. Date signed 5/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-0)

CERTIFICATE OF DEATH

BC

04801

Reg. Dist. No. 38

1. PLACE OF DEATH: Jacto

County

City or town (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Mercy Villa - Bellona Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1421 E. Federal St. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME MARGARET R. STANDIFORD

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Charles L. Standiford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 20, 1888

8. AGE: Years	Months	Days	If less than one day
56	7	26	..... hrs. ..... min.

9. Birthplace: Balto., Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: John Katzenberger

13. Birthplace: Ga.

MOTHER — 14. Maiden name: Mary Jane Malone

15. Birthplace: N. Y.

16. Informant: Mrs. C. Preston Scheffenacker

Address: 5015 Greenleaf Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/19/45 (month) (day) (year)

Cemetery or crematory: New Cathedral Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5/17 1945 (Date received by registrar) D M Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16, 1945, at 2:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 6 1945, to May 16 1945

and that I last saw h[illegible] alive on May 16 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to:	
Due to: Nephritis - Renal Ves	4 yrs.
Toxemia of Pregnancy	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

SIGNATURE L. H. Meyer Jr M. D. or other

Address 520 E 33rd Date signed 5/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-A)

04802

CERTIFICATE OF DEATH

Reg. Diat. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 4112 Northern Parkway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph Francis Starr

3.(b) Social Security Number ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B.(b) Name of husband or wife: Dorothy Pursell
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): December 29, 1891

8. AGE: Years	Months	Days	If less than one day
53	4	3	....hrs. ....min.

9. Birthplace: Fort Mead, S. D. (Town, county, and state)
10. Usual occupation: Engineer
11. Industry or business: Shipbuilding

FATHER
12. Name: Charles E. Starr
13. Birthplace: ?

MOTHER
14. Maiden name: Mary Alice Cayhill
15. Birthplace: ?

16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4 1945 (month) (day) (year)
Cemetery or crematory:
Location: Omaha Nebr
18. Funeral director: John C Mann
Address: 3000 E Baltimore St

19. 5/2 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1945, at 10:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945, to May 2 1945 and that I last saw h... im ...alive on May 2 1945

Immediate cause of death	DURATION
Acute myocardial insufficiency	4 days
Due to: Chronic hypertensive cardio-vascular disease with aortic	
Due to: regurgitation	Indef.
Other conditions: Psychosis with organic disease	m

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M. D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville, Balto.-28, Md. Date signed: 5/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

T

04803

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balt.
City or town: Catonsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred: Spring Grove State Hosp
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Calvert
City or town: Lusby (If outside city or town limits write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Odie Stinnett
3.(b) Social Security Number

4. Sex: M
5. Color or race: W
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years 64 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Agriculture
FATHER 12. Name: unknown
13. Birthplace: "
MOTHER 14. Maiden name: "
15. Birthplace: "
16. Informant: Hosp. Records
Address: Catonsville 28 Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 5 45 (month) (day) (year)
Cemetery or crematory: Emanuel Church Cem
Location: Calvert Count
18. Funeral director: [illegible]
Address: [illegible]
19. 5/5 1945 H. C. Andrews Deputy Local Reg. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945, at 9:35 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Acute myocardial failure	
Due to Cardio vascular disease	
Due to fractured right humerus due	
Other conditions to falling out of bed	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: as above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: accident Date of: unknown
Where did injury occur? Lusby (City or town) Calvert (County) Md (State)
Injured at home, farm, industry, public place (where?) home
Means of injury: fall out of bed Injured at work? no

23. SIGNATURE Geo. W. Kieffer Dep. Med. Exam. Balt. Co. M. D. or other
Address 1010 Leeds ave Date signed 5-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04804

Reg. Dist. No. 32

1. PLACE OF DEATH:
County: Baltimore
City or town: Mount Wilson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 0 yrs., 3 mos., 26 days
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. Tuberculosis Sanatorium
How long in hospital or institution? 0 yrs., 3 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2728 Hugo Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Marie E. Swindell

3.(b) Social Security Number: No. Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Richard Swindell
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 21, 1891

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	1	23		

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Frank Vitch
13. Birthplace: Unknown

MOTHER
14. Maiden name: Mary Klima
15. Birthplace: Czechoslovakia

16. Informant: Mrs. Marie E. Swindell
Address: 2728 Hugo Ave., Balto., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 17, 1945 (month) (day) (year)
Cemetery or crematory: Louden Park Cemetery
Location: Baltimore, Maryland

18. Funeral director: Wm. J. Tickner & Sons
Address: Pa. & North Aves., Balto., Md.

19. May 14, 1945 (Date rec'd by registrar) Earl T. Webster Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1945, at 8:10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 18, 1945 to May 14, 1945 and that I last saw her alive on May 14, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	2½ yrs.
Due to: Tubercle Bacilli	
Due to:	
Other conditions: Tuberculous Laryngitis	9 mos.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: No Autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

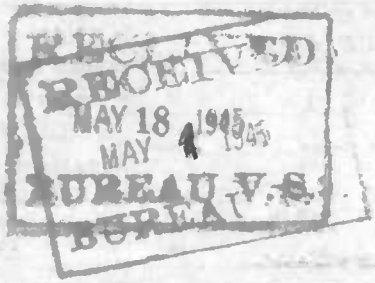
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Stewart A Shaffer M.D. (M. D. or other)
Address: Mt. Wilson, Md. Date signed: 5/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15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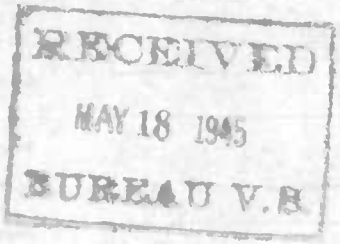
MAY 1945
BUREAU V.S.


RECEIVED
MAY 18 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04805

Reg. Dist. No. 30

B

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 4 months, 13 days
Hospital, Institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 4 years, 4 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore Co.
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2915 Hillcrost Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: nd

3.(a) FULL NAME: Frances Sylvester

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Sylvester
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1886

8. AGE:	Years	Months	Days	If less than one day
about	59	?	?	..... hrs. ..... min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: Joseph Paskowski
FATHER 13. Birthplace: Poland
MOTHER 14. Maiden name: Mary Stankowski
MOTHER 15. Birthplace: Poland
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/4/45 (month) (day) (year)
Cemetery or crematory: Holy Rosary
Location: Balto. Md.
18. Funeral director: William Cook Inc
Address: 1217 St. Paul St.
19. 5/3 (Date rec'd by registrar) 19 45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 1 19 45 at 6:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18 19 40 to May 1 19 45 and that I last saw her alive on May 1 19 45

Immediate cause of death	DURATION
Left lower lobe pneumonia, terminal	14 hours
Due to: Myocardial failure	1 week
Due to: Chronic hypertensive cardio-vascular disease	Indefinite
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robert E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Maryland Date signed: 5/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (13-a)

Reg. Dist. No. 32

CERTIFICATE OF DEATH

04806

1. PLACE OF DEATH:
(a) County Baltimore
(b) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: 4 V 34 Milford Mill Road.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 19 yrs

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Baltimore
(c) City or town Pikesville
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4 V 34 Milford Mill Road.
(If rural give location)
(e) If foreign born, how long in U. S. A.? ____ years

3 (a) **FULL NAME** ELVIA IOLA RYAN TALBOTT

3 (b) If veteran, name war

3 (c) Social Security No.

4 Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: William C. Talbott.

6. (c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): March 14 1881

8. AGE: Years: 64 Months: 2 Days: 11 If less than one day: ____ hr. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: William R. L. Ryan
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden Name: Mary A. Smith
15. Birthplace: A. A. Co. Md.

16 (a) Informant: William C. Talbott
(b) Address: 4 V 34 Milford Mill Rd. Pikesville Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof: May 15 1945 (month) (day) (year)
(c) Cemetery or crematory: Loudon Park Cem.
Location: Baltimore, Md.

18 (a) Funeral director: G. Willis Lamorean
(b) Address: 4510 Liberty Heights Ave

19 (a) 5/16/45 (Date rec'd by registrar) (b) Alice Hedrick Registrar

MEDICAL CERTIFICATION

20. Date of death May 12 1945, at 1.40 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from Oct 1 1944, to May 12 1945 and that I last saw him alive on May 12 1945.

Immediate cause of death	Duration
(a) Cerebral hemorrhage	10 days
Due to Arterio sclerosis	1 yr
Due to Nephritis Glomerular	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Lyman Post, Jr. M. D. or other
Address 1707 N. Howard St. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH 55-e

Registered No. 4472 C2807

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH ~~County~~

(a) Baltimore ~~City~~, Maryland Halethorpe

(b) Street address 5535 Willys Ave.

(c) Hospital or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Md. (b) County Baltimore

(c) City or town Halethorpe
(If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Grace Joan Taylor

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
F	W	

6 (b) Name of husband or wife

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 28, 1942

8. AGE: Years	Months	Days	If less than one day
3	1	7	hr. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual Occupation

11. Industry or business

FATHER

12. Name John Taylor

13. Birthplace Philadelphia, Pa.

MOTHER

14. Maiden Name Doris Zinsmeister

15. Birthplace Baltimore, Md.

16 (a) Informant Doris Zinsmeister

(b) Address 5535 Willys Ave.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 8, 1945 (month) (day) (year)

(c) Cemetery or crematory Mt. Olivet

Location Baltimore

18 (a) Funeral director Frederick A. Cole

(b) Address 1700 W. Lombard St.

19 (a) May 8 45 (Date rec'd by registrar) (b) May 8-45 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5, 1945, at 11 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to May 5 1945, and that I last saw h— alive on May 5 1945.

	Duration
Immediate cause of death Pleural Effusion (Carcinomatosis of Peritoneum & Pleura)	
Due to Cord and Brain.	
Due to Cardiac Failure	
Other Conditions Pulmonary Edema	

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Robert C. Hatch M. D.

Address 2151 Wells Ave Date signed 5/13/45

VS 150

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

Evidence for change of age & birth date of deceased is shown on FILM No. G 95 MAY 28 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4620)

CERTIFICATE OF DEATH

04808

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Balto Co
City or town: Catonsville Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Balto Co
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 112 S Cunningham ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Thomas.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

6.(b) Name of husband or wife: Augusta L. Thomas
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 3 1871

8. AGE: Years	Months	Days	If less than one day
73	9		hrs. min.

9. Birthplace: Balto City Md. (Town, county, and state)
10. Usual occupation: Salesman.
11. Industry or business: Mattress fact.
FATHER 12. Name: Julius Thomas.
FATHER 13. Birthplace: Germany.
MOTHER 14. Maiden name: ?
MOTHER 15. Birthplace: New York
16. Informant: Augusta L. Thomas
Address: 112 S.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/19/45 (month) (day) (year)
Cemetery or crematory: London Park
Location: Balto City Md
18. Funeral director: Edw. S. Mac Nabb
Address: Catonsville Md.
19. 5/19/45 (Date rec'd by registrar) (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1945, at 2:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 1944, to May 16 1945
and that I last saw him alive on May 15 1945

Immediate cause of death	DURATION
Carcinoma - Rectum	9 mo.
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: S. Hoyt Johnson M. D. or other
Address: Catonsville. Date signed: May 16 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M-N 26b

04809 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 Days
Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Ft. Howard, Maryland
How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1020 Booth Street
(If rural, give LOCATION)
2.(a) If veteran, name war: WW-I

3.(a) FULL NAME: WILLIAM E. TINSLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widowed

6.(b) Name of husband or wife: Widowed
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28, 1889

8. AGE:	Years	Months	Days	If less than one day
	56	2		hrs. min.

9. Birthplace: Jefferson City, Mo.
(Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business

FATHER
12. Name: James Tinsley
13. Birthplace: Missouri

MOTHER
14. Maiden name: Jeanette Hayes
15. Birthplace: Missouri

16. Informant: Clinical Records, Vets. Adm. Fac.
Address: Ft. Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-1-45 (month) (day) (year)
Cemetery or crematory: Baltimore National Cemetery
Location: Baltimore, Md.

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 5/31/45 (Date rec'd by registrar) Accepted (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28, 1945 19 at 12:00 Midnight M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22, 1945, to May 28, 1945 and that I last saw him alive on May 28, 1945

Immediate cause of death	DURATION
Tuberculosis, chr. pul. far Adv.	2 Yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT. COL., M.C. CLIN. DIR.
Address: Ft. Howard, Md. Date signed 5-29-45

M (M) MARGIN RESERVED FOR BINDING I (I) PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. T (T) VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

T 04810

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:

County Baltimore

City or town Owings Mills Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yrs

Hospital, institution, or street address where death occurred: Gwynns Mills Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Owings Mills Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Gwynns Mill Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Ellen Interrouble

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Charles E. Interrouble

6.(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1863

8. AGE: Years	Months	Days	If less than one day
81	7	24	...hrs. ...min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Home

FATHER
12. Name David Brotherton
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Mary Roache
15. Birthplace Baltimore, Md

16. Informant Bessie Weidman
Address Owings Mills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/28/45 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Anne Arundel Co. Md

18. Funeral director Geo. Putty, Jr.

Address 1735 Harford Ave

19. 5/26/45 Tom E. Martin
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1945 at 12-a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 19 45, to May 26, 19 45

and that I last saw h.e.r. alive on May 27 19 45

Immediate cause of death ...Pneumonia, Chronic interstitial

Duration 3 Unknown Cor. R.

Due to

Due to

Other conditions Chronic Arthritis deformans

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Tom E Martin
M. D. or other

Address Randallstown, Md Date signed 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

FILM No. G 96 JUL 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

04811 P

Reg. Dist. No.

1. PLACE OF DEATH: Baltimore Co.

County THE SHEPPARD & ENOCH PRATT HOSPITAL

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 22 days

Hospital, institution, or street address where death occurred: Sheppard & Enoch Pratt Hospital, Towson, Md.

How long in hospital or institution? 4 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infante give residence of mother)

State District of Columbia County

City or town 7200 Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 7200 Connecticut Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Louise Bride Varnell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Malcolm K. Varnell

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): November 3, 1885

8. AGE: Years	Months	Days	If less than one day
59 -60-	6	19	....hrs. ....min.

9. Birthplace: Washington, D.C.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Carter Bride

13. Birthplace: Washington, D.C.

MOTHER 14. Maiden name: Louise Witthaft

15. Birthplace: Washington, D.C.

16. Informant: Hospital Records

Address

17. (Burial, cremation, or removal. Which?) Removal Date thereof 5/23/45 (month) (day) (year)

Cemetery or crematory: Washington D. C.

Location

18. Funeral director: William J. Tickner & Sons

Address: North & Pennsylvania Aves

19. (Date rec'd by registrar) 6/23 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1945 to May 22, 1945 and that I last saw her alive on May 22, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	12 hrs.
Due to: Cardiovascular renal disease	Unk.
Due to: Generalized arteriosclerosis	Unk.
Other conditions: Involutional Melancholia	Unk.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: Confirms above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Arthur H. Havell, M.D. M. D. or other

Address: Sheppard-Pratt Hospital Date signed 5/22/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04731

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years, 23 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 8 years, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3612 Cedardale Road
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Emma K. Vander Horst

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Herman H. Vonder Horst

6.(c) If alive, give age .... years

7. Birth date of deceased (mo., day, yr.): March 26, 1864

8. AGE: Years	Months	Days	If less than one day
81	1	13	.... hrs. .... min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER 12. Name: Herman Kuhlmann

13. Birthplace: Germany

MOTHER 14. Maiden name: Eliza Bender

15. Birthplace: Germany

16. Informant: Hospital records

Address: Catonsville-28, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/11/45 (month) (day) (year)

Cemetery or crematory: Loudon Park Cem.

Location: Balto., Md.

18. Funeral director: WM. J. TICKNER & SONS

Address: Balto., Md.

19. 5/11 19 45 (Date rec'd by registrar) H. C. Andrews Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9 19 45, at 2:00 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h.... alive on .... 19....

Immediate cause of death: Bronch. Pneumonia

Due to: Arterio sclerosis

Due to: fractured left femur neck

Other conditions: Accident

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations .... Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: April 26, 45 12:05 am

Where did injury occur? Catonsville Balto. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where)? Spring Grove State Hosp.

Means of injury: fall on the floor (Halls). Injured at work? no

23. SIGNATURE: Geo. McKieffer for [illegible] M. D. or other

Address: 1010 [illegible] Date signed: 5-9-45

BC

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

T 04812

Reg. Dist. No. 30

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 yrs., 3 mos., 7 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 13 yrs., 3 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 122 N. Bradford Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Fannie Viscuso

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Vincent Viscuso

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): February 25, 1887

8. AGE: Years	Months	Days	If less than one day
58	3	1	....hrs. ....min.

9. Birthplace: Roumania (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: House

FATHER 12. Name: ?

FATHER 13. Birthplace: ?

MOTHER 14. Maiden name: ?

MOTHER 15. Birthplace: ?

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)

Cemetery or crematory: Spring Grove State Hospital

Location: Catonsville 28, Maryland

18. Funeral director: Spring Grove State Hospital

Address: Catonsville 28, Maryland

19. ....19.... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 19 45, at 8:35 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 19 32, to May 26 19 45

and that I last saw her alive on May 26 19 45

Immediate cause of death: Chronic myocardial insufficiency — DURATION: Indef.

Due to: Cardiovascular-renal disease — DURATION: "

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robt. E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed: 5/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

VS A15 — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

T 04813

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:
County: Baltimore
City or town: Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Notch Cliff near Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sister Mary Philoea Wagner
3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Nov. 25, 1876
8. AGE: Years 68 Months 6 Days 5 If less than one day ... hrs. ... min.
9. Birthplace: Treverton, Pa (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business:
FATHER 12. Name: Alexander Wagner
13. Birthplace: Germany
MOTHER 14. Maiden name: Marie Freiheit
15. Birthplace: Germany
16. Informant: Sr. Mary Clara
Address: Notch Cliff, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1 45 (month) (day) (year)
Cemetery or crematory: Notch Cliff
Location: Glen Arm
18. Funeral director: Geo M. Smith Son
Address: 811 N. Wolfe St.
19. 5/31/45 (Date rec'd by registrar) 19 ... [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945, at 2.25 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22 1944, to May 30 1945 and that I last saw her alive on May 18 1945

Cause	Duration
Immediate cause of death: Apoplexy	5 wks
Due to: Arterio-sclerosis	
Due to: & hypertension	[illegible]
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: ... Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Towson - Md. Date signed: 5/30/45

VS A15 (7) MARGIN RESERVED FOR BINDING (1) (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45-f)

04814

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:
County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years, 1 month, 8 days
Hospital, institution, or street address where death occurred:
Spring Grove State Hospital
How long in hospital or institution? 4 years, 1 month, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince Georges
City or town: Capitol Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 310 Kingston Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Sarah Watson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William E. Watson
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): March 16, 1860

8. AGE: Years	Months	Days	If less than one day
85	2	14	..... hrs. ..... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER 12. Name: James Nash
13. Birthplace: Virginia
MOTHER 14. Maiden name: Margaret ?
15. Birthplace: Virginia
16. Informant: Hospital records
Address: Catonsville, Balto.-28, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-2-45 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: William Chambers
Address: Washington D.C.
19. 5/31/45 (Date rec'd by registrar) W.C. Rodbell Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 19 45, at 9:30 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 19 41, to May 30 19 45
and that I last saw h...er ...alive on May 30 19 45

Immediate cause of death	DURATION
Carcinoma of the pharynx	Indef.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.
Robt. E. Gardner, M.D. M. D. or other
Address: Catonsville-28, Md. Date signed: 5/30/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04815

Reg. Dist. No. 4-1

1. PLACE OF DEATH:

County: Baltimore

City or town: Fort Howard
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 Days

Hospital, institution, or street address where death occurred:
Vets. Adm. Fac. Fort Howard, Maryland

How long in hospital or institution? 5 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1123 S. Hanover St.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW-2

3.(a) FULL NAME: RALPH WEAVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Clara Mae Weaver

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 9-24-02

8. AGE:	Years	Months	Days	If less than one day
	42	7	24	....hrs. ....min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Electrician Helper

11. Industry or business:

FATHER — 12. Name: Virgil Weaver
13. Birthplace: Virginia

MOTHER — 14. Maiden name: Sally Calgton
15. Birthplace: Virginia

16. Informant: Clinical Records
Address: Fort Howard, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-22-45 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery
Location: Arlington, Virginia

18. Funeral director: A. Lee Oder
Address: 4644 York Road., Balto., Md.

19. 5/19/45 (Date rec'd by registrar) 19 Milton M. Emerson Registrar
Dep.

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18, 1945, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1945, to May 18, 1945 and that I last saw him alive on May 18, 1945

Immediate cause of death	DURATION
Lobar Pneumonia	
Due to	
Due to	
Other conditions: Hepatitis, Gastritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....

Autopsy results: Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A.M. Balter
A.M. BALTER, LT.COL., M.C. CLIN. DIR.

Address: Fort Howard, Maryland Date signed: 5-19-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04816

Reg. Dist. No. 44

1. PLACE OF DEATH:
County: Baltimore
City or town: Middleborough
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Middleborough
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 169 Wye Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ABBIE B. WHITING

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles P. Whiting. 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 8, 1883

8. AGE: Years	Months	Days	If less than one day
61	5	24	hrs. min.

9. Birthplace: Sullivan Co. N.Y. (Town, county, and state)

10. Usual occupation: Glenn L. Martin Co.

11. Industry or business

FATHER — 12. Name: Martin Benton
13. Birthplace: New York

MOTHER — 14. Maiden name: Sarah Bryan
15. Birthplace: Sullivan Co. N.Y.

16. Informant: Mrs. J. T. Lyons
Address: 169 Wye Road.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5, 1945 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn, Md.

18. Funeral director: Ullrich Funeral Home
Address: 2008 Orleans St.,

19. 5/5/45 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 19 45 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29 19 45 to May 5 19 45 and that I last saw h[illegible] alive on May 5 19 45

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward M. Kemmerly M. D. or other
Address: Essex Md. Date signed: 5/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CHANGE OF NAME: : Film G05 5-28-45 II

04817 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

Reg. Dist. No. .....

1. PLACE OF DEATH:
County ..... Balto.
City or town ..... Towson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ..... Md. County ..... Balto.
City or town ..... Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. ..... 105 Burke Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME DAVID DAVIS W. WHITE

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife ..... M. Elizabeth White
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 31, 1870

8. AGE: Years	Months	Days	If less than one day
74	4	19	..... hrs. ..... min.

9. Birthplace ..... Baltimore, Md.
(Town, county, and state)
10. Usual occupation ..... Wholesale Mgr. (retired 10 yrs.)
11. Industry or business ..... Lambert Automobile Co.

FATHER
12. Name ..... Nathaniel S. White
13. Birthplace ..... Balto., Md.

MOTHER
14. Maiden name ..... Georgeanna De Shon
15. Birthplace ..... Winchester, Va.

16. Informant ..... Mrs. M. Elizabeth White
Address ..... 105 Burke Ave., Towson, Md.

17. ..... Burial ..... Date thereof 5/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory ..... Woodlawn Cem.
Location ..... Woodlawn, Md.

18. Funeral director ..... WM. J. TICKNER & SONS
Address ..... Balto., Md.

19. ..... 5/22 ..... 19 45 ..... A. W. Hedrick ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH ..... May 20, ... 19 45 ..... at 9:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May ..... 19 43 ..... to May 20th 19 45
and that I last saw h.. alive on May 20th 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to Senile Arteriosclerosis	
Due to Myocardial disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to extereal causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Daniel H. Thompson M. D. or other
Address Towson 4, Md. Date signed May 22, 1945

M

I

T

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1952)

CERTIFICATE OF DEATH

104818

Reg. Diat. No. 50

1. PLACE OF DEATH:

County Balto

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 yrs, 2 months, 7 days

Hospital, Institution, or street address where death occurred: Spring Grove State Hosp

How long in hospital or institution? 23 years, 2 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. unknown

(If rural, give LOCATION)

2.(a) If veteran, name war --

3.(a) FULL NAME Joseph Wintowicz

3.(b) Social Security Number --

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

B.(b) Name of husband or wife

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 1890 ?

8. AGE: Years	Months	Days	If less than one day
55 ?			hrs. min.

9. Birthplace unknown (Town, county, and state)

10. Usual occupation unknown

11. Industry or business

FATHER 12. Name unknown

FATHER 13. Birthplace unknown

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Hospital records

Address Catonsville, Baltimore - 28, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 6, 1945 (month) (day) (year)

Cemetery or crematory Spring Grove State Hospital

Location Catonsville 28, Maryland

18. Funeral director Spring Grove State Hospital

Address Catonsville 28, Maryland

19. 6/6 1945 (Date rec'd by registrar) W. C. Andrews Registrar

Deputy Local

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28, 1945 at 7.25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Lemonhage	
Due to Ruptured Spleen and Liver	
Due to	
Other conditions Accident	

(Include pregnancy within 3 months of death)

Major findings of operation Ruptured Spleen & liver with hemorrhage Date of op. May 29, 45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 1 P M

Accident, suicide, or homicide Accident Date of May 27, 45

Where did injury occur? Catonsville (City or town) Balto (County) Md (State)

Injured at home, farm, industry public place (where?) Hospital

Means of injury Falling plaster from ceiling Injured at work? no

23. SIGNATURE Geo. McKie Edwards M. D. or other

Address 1010 Leadenhall Date signed May 28, 45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

13C 1

04819

Reg. Dist. No. 30

VS A15 (1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Baltimore

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred: Spring Grove State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore-24

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3224 E. Baltimore Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Renard Wolfgram (Wolfgran)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of husband or wife: - - -

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 30, 1905

8. AGE:	Years	Months	Days	If less than one day
	39	9	29	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Transit company

FATHER — 12. Name: William Wolfgran

FATHER — 13. Birthplace: ? Baltimore Md

MOTHER — 14. Maiden name: Mary E. Deegan

MOTHER — 15. Birthplace: ? Baltimore Md.

16. Informant: Hospital records

Address: Catonsville, Balto.-28, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1 1945 (month) (day) (year)

Cemetery or crematory: Baltimore Hebrew

Location: Walker Ave

18. Funeral director: John C. Moran

Address: 3000 E. Baltimore St

19. 5/29 1945 (Date rec'd by registrar) W. C. Rhodes Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29 1945 at 11:10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1945, to May 29 1945

and that I last saw him alive on May 29 1945

Immediate cause of death	DURATION
Uremia	12 hrs.
Due to Chronic interstitial nephritis.	
Duration: Indefinite. C.W.G.R.	
Due to	
Other conditions Congenital lobulated kidneys. both sides.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert E. Gardner M.D.

Robt. E. Gardner, M.D. M. D. or other

Address: Catonsville-28, Md. Date signed 5/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

04820 P 41

Reg. Dist. No. .....

1. PLACE OF DEATH:
County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? .....
Hospital, institution, or street address where death occurred:
201 Patapsco Ave.
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Balto.
City or town Dundalk
(If outside city or town limits, write RURAL and give nearest town)
Street No. 201 Patapsco Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME William Robert Woolsey

3.(b) Social Security Number 214-10-0131

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Carrie R. Woolsey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 19, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	9	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Clerk Accounting Dept.
11. Industry or business Bethlehem Steel Co.

FATHER
12. Name William Woolsey
13. Birthplace Balto., Md.

MOTHER
14. Maiden name Virginia Holmes
15. Birthplace Balto., Md.

16. Informant Mrs. Carrie Woolsey
Address 201 Patapsco Ave., Dundalk, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/30/45 (month) (day) (year)
Cemetery or crematory Oaklawn Cem.
Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS
Address Balto., Md.

19. 5/29 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945 at 5:45 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1943 to May 28 1945 and that I last saw him alive on May 28 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Howard Burns M. D.
M. D. or other
Address Dundalk 22 Md. Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2411 Chanes. Ct

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

04821

CERTIFICATE OF DEATH

Reg. Dist. No. 34

1. PLACE OF DEATH:
County: Baltimore
City or town: Govs Run
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Govs Run
(If ontside city or town limits, write RURAL and give neurest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harvey J Zeigman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Melvina Zeigman
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): Nov 28-1878

8. AGE:

Years	Months	Days	If less than one day
66	5	9	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business

FATHER
12. Name: William Zeigman
13. Birthplace: Md

MOTHER
14. Maiden name: Lydia Ballinger
15. Birthplace: Md

16. Informant: Mrs Harvey J Zeigman
Address: Hampstead Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 45 (month) (day) (year)
Cemetery or crematory: Shultz's
Location: York Co. Penna

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. May 7 1945 (Date rec'd by registrar) L. E. Fowble M.D. Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1945 at 7 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1938 to May 7 1945 and that I last saw him alive on May 6. 1945

	DURATION
Immediate cause of death: Cerebral Hemmorage	4 da.
Due to: Cirhosis - Selective Cardio - Renal	
Due to: Vascular Lesions	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please nnderline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Msens of injury — Injured at work?

23. SIGNATURE: Joel E. Buckingham M. D. or other
Address: Hampstead Md Date signed 5-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 04822 — Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Parkville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
2933 Willoughby Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Parkville
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2933 Willoughby Avenue-14-
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Anna Zimmerer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: George S. Zimmerer
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Sept. 2, 1896

8. AGE: Years	Months	Days	If less than one day
48	8	20	____ hrs. ____ min.

9. Birthplace: at home (Town, county, and state)
10. Usual occupation: Baltimore, Md.
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr. George S. Zimmerer
Address: 2933 Willoughby Avenue-14-

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/25/45 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore

18. Funeral director: Leonard J. Ruck
Address: 5305 Harford Road

19. 5/23 1945 (Date rec'd by registrar) — A. M. Bacon, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22 1945, at 10.36 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 13 1942, to May 22 1945
and that I last saw h[er] alive on May 22 1945

	DURATION
Immediate cause of death: Thrombosis coronary	
Due to: Arteriosclerosis	Thrombosis about
Due to: Hypertension and Arteriosclerotic myocarditis	3 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: A. M. Bacon, M.D. (M. D. or other)
Address: 2810 Taylor Ave. Date signed: 5/23/45

(M) (1) (T) VS A15

MARGIN RESERVED FOR BINDING

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